Maryland
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ANNUAL MEETING, MAY 2, 3, 4, 1956

MEDICAL AND CHIRURGICAL FACULTY

Plan your schedule to participate in the Annual Meeting functions that have been arranged by the Committee on Scientific Work and Arrangements.

WEDNESDAY, MAY 2, 1956

The morning will be set aside for the meeting of the House of Delegates, which will be held in Osler Hall of the Medical and Chirurgical Faculty Building. All members of the Faculty are most welcome. When you attend these meetings you will be conversant with the activities of the officers and committees of your Association and will understand the work that is being accomplished for the people in Maryland through your State Medical Society. The Council meeting, which will precede the House of Delegates, will be held in the Friedenwald Room of the Faculty Building.

LUNCHEON

Sheraton Belvedere Hotel

This is under the auspices of the Woman's Auxiliary to the Medical and Chirurgical Faculty, and the members, their wives, and guests are welcome.

AFTERNOON SCIENTIFIC SESSION

Osler Hall, 1211 Cathedral Street

Present Status of Hypothermia in Surgery and Medicine. Robert D. Dripps, M.D., Philadelphia, Pennsylvania.

Surgical Treatment of Diseases of the Thyroid Gland. William F. Rienhoff, Jr., M.D., Baltimore, Maryland.

EVENING MEETING

Osler Hall, 1211 Cathedral Street

8:00 P.M.

Back Injuries—Their Causes and Sequelae. Panel Discussion with Raymond K. Thompson, M.D., Baltimore, as Moderator. Participants will be: George E. Bennett, M.D., Baltimore; Harry F. Klinefelter, Jr., M.D., Baltimore; and Walter V. Harrison, Esq., Baltimore.

THURSDAY, MAY 3, 1956

There will not be any business sessions held on Thursday.

MORNING SCIENTIFIC SESSION

Osler Hall, 1211 Cathedral Street

The Gastrointestinal Tract as a Semipermeable Membrane and its Relation to Water, Electrolytes, and Nutrient Particles. Lay Martin, M.D., Baltimore, Maryland.

Hospitalizing the Psychiatric Patient. Irving J. Taylor, M.D., Ellicott City, Maryland.

Treatment of Peripheral Vascular Disease. Richard T. Shackelford, M.D., Baltimore, Maryland.

Election of Board of Medical Examiners.

Necrology. A. S. Chalfant, M.D., Chairman, Memoir Committee of the Medical and Chirurgical Faculty.

The Lipid-Cholesterol Problem in Relation to Coronary Artery Disease. Martin L. Singewald, M.D., Baltimore, Maryland.

ROUND TABLE LUNCHEON

Sheraton Belvedere Hotel

There are subjects of interest to all, and each table has a moderator to lead the discussion.

AFTERNOON SCIENTIFIC SESSION

Osler Hall, 1211 Cathedral Street

The Evolution of Public Health as a Medical Specialty. Ernest L. Stebbins, M.D., Baltimore, Maryland.

Current Views on Management in Cardiac Infarction. Robert L. Levy, M.D., New York City.

The Epidemiology and Modern Concepts in the Management of Tuberculosis. Panel Discussion.

EVENING MEETING

Sheraton Belvedere Hotel

Cocktails, 6:00 P.M.

Everyone attending the Presidential Dinner, at 7:00 p.m., is invited to the cocktail party as guests of the Baltimore City Medical Society.

(*Continued on next page*)

Thursday, May 3, Evening Meeting, Continued

Presidential Dinner, 7:00 P.M.

(Dress Optional)

Members and their guests are cordially invited to attend this dinner. Among other features at the dinner will be:

Presidential Address. The Practice of Preventive Medicine. William H. F. Warthen, M.D., Towson, Maryland.

Management of Mass Casualties. Colonel Joseph R. Shaeffer, Chief Surgical Consultant, Department of the Army, Washington, D. C.

Members who cannot attend the dinner are invited to be present at the general meeting in order to hear the above speakers.

FRIDAY, MAY 4, 1956

There will be a business session of the House of Delegates Friday morning in Osler Hall, 1211 Cathedral Street. No scientific sessions will be held at this time.

AFTERNOON SCIENTIFIC SESSION

Osler Hall, 1211 Cathedral Street

Water Intoxication in Common Problems of Pediatrics and Surgery. Robert E. Cooke, M.D., New Haven, Connecticut.

New Approaches to the Treatment of Psychiatric Disorders. Frank J. Ayd, Jr., M.D., Baltimore, Maryland.

Clinical Pathological Conference. This has been arranged by The Johns Hopkins University School of Medicine and the University of Maryland School of Medicine.

FRIDAY EVENING

The Alcazar, Cathedral and Madison Streets

The Ball, which will be held again this year, will be sponsored by the Woman's Auxiliary to the Baltimore City Medical Society. All members and their guests are invited to attend. The proceeds from this Ball are used to aid medical students, nurses, and medical technology students.

Talbot County Issue

THE FIRST FIFTY YEARS OF A COMMUNITY HOSPITAL

WILLIAM N. PALMER, M.D.

The Eastern Shore of Maryland has always been known as a delightful land of abundance and pleasant living. Situated as an appendage bounded on the east by the ocean and separated from the mainland by the Chesapeake Bay, it is crisscrossed with rivers and smaller bays.

Prior to 1907, this desirable geographical independence meant terror for anyone acutely ill. The roads were small, winding, and usually patterned after original Indian trails. Until rather recently one highway near Easton crossed the same railroad tracks seven times in less than ten miles. Most of the travelling was by horse, although a few of the more daring had motor runabouts.

A patient with a ruptured appendix, if fortunate enough to get an early diagnosis, had several choices; he could stay at home and die; or he could be taken to Easton Point to be loaded on the night boat at 9 P.M. to arrive at the Light Street Dock in Baltimore at 7 A.M. the following day (a patient from Denton would have taken the boat at about noon the day before for his trip across the Bay); or he could leave Easton on the 7 A.M. train, change trains at Clayton, change again at Wilmington, and wait for a Baltimore-bound coach on the Washington-New York Line, a trip that required about nine hours if connections were good. The morning and afternoon trains would put him in Philadelphia in about six hours, but with two changes. Thus train or boat were the only life-saving means, because driving around the head of the Bay was dangerous and too time-consuming.

The present native Eastern Shoreman is a rugged individualist, but his parents fifty years ago probably exhibited even more of this trait. The farmers and watermen did not defer lightly to a slight case of "locked bowels" or an attack of "indigestion." By the time home remedies were abandoned and a doctor was called, the patient was ordinarily in too critical a condition for any sort of earthly transportation.

Along with the growth of population in this community came an awareness of the gravity of its isolation from the city hospitals. With more enthusiasm than practicability a forward-looking group rented the upper two floors of a vacant hotel in the center of the town of Easton. Members of the board were elected and the Emergency Hospital was about to become a fact. (Fig. I).

The hospital was opened for patients in February 1907 and had cared for 176 patients by December 1, 1907. The original staff consisted of two surgeons and three general practitioners. One of the resolutions of the Hospital Association was to the effect that "the hospital should not at any time be left without the presence in the building of at least one graduate nurse."

Extracts from the early Constitution and By-Laws are interesting:

> There shall always be maintained in the Hospital a colored ward, with provision for four or more beds.

FIGURE I

No fee shall be charged a person who is unable to pay, and such patients shall receive the same care and attention as pay patients.

Patients who are able to pay shall be charged at the minimum rates of $8.00, $12.00, and $15.00 per week for a private room, and from $2.00 to $5.00 per week for treatment in the wards. These charges to include board, fuel, lights and attention of the nurses. The laundry of a patient will not be attended to in the Hospital except in special cases where the Superintendent so directs.

There must have been some complaints about the exorbitant cost of hospitalization, for there is a sort of apologia in the President's report of 1909; "We are charging from $10.00 to $15.00 per week for private rooms, which is not as much as charged by the hotels, where nothing is given but board and lodging."

A few other excerpts from the same report are of interest:

The great bulk of our patients are accepted without any charge, or for small amounts such as the patients seem disposed to contribute. No one is denied admission because of lack of funds, consequently we find ourselves in a position, where the amount received from board and care pays about one-third of the expense of running the Hospital, and the Management have to look to charitable institutions to make up the remainder. I am pleased to report that up to the present time the public has responded to our appeals and enabled us to meet the necessary expenses.

Of the two hundred and sixty-eight patients admitted during the past year, one hundred and one were absolutely free; one hundred and twenty-six paid sums running from $1.00 to $5.00 per week and forty-one paid the full charges for rooms, $10.00, $12.00 and $15.00 according to situation—the $10.00 rooms being the most in demand.

During last year a course of lectures were conducted by the Members of the Staff and the Superintendent, and certificates were given to three of the young ladies who had served a term of two years. Two of them have gone out and found profitable employment in nursing the sick, and the third one has remained in the employ of the Hospital at the request of the Board.

Report of the Treasurer

M. B. Dixon, Treasurer, In Account With The Emergency Hospital,—Annual Statement, December 1st, 1908 to December 1st, 1909.

Receipts

Balance December 1, 1908	$ 52.06
State appropriation	3,500.00
Board and care	2,833.78
Hospital Day	873.23
Churches	174.63
Borrowed from Easton National Bank	597.80
Subscriptions	379.80
For heating Sturmer's store	35.00
Rent from stables	24.00
Other sources	13.55
Total receipts from Dec. 1st, 1908 to Dec. 1st, 1909	$8,483.55

Expenditures

Note due A. E. Rathell & Co.	$ 500.00
Salaries	2,568.67
House expenses	1,885.32
Paid Easton National Bank	597.50
Interest	4.28
Coal, Wood and Insurance	391.86
Rent	408.34
Gas	264.15
Water	50.00
Repairs	106.05
Stamps & Stationery	51.91
Telephone	36.95
Ambulance	33.00
Hospital expenses	825.27
Total expenses, Dec., 1908 to Dec., 1909	7,723.30
Balance in Easton National Bank	760.25
	$8,483.55

MARY B. DIXON, Treas.

By 1911, when I joined the Staff, there were two other surgeons and four general practitioners, a two-year training school for nurses had been established, and the patient load had increased to 372. Three counties, Talbot, Queen Anne's, and Caroline—supported the obligations vigorously, but it was obvious that the hospital was working in excess of its facilities.

I remember that the operating room was on the third floor and that the elevator was powered by a stout hairy rope. On the day when I was the surgeon the anesthetist pulled the rope. On the next day when I was the anesthetist, I pulled the lift because then it would make no difference about rope splinters in the hands when scrubbing.

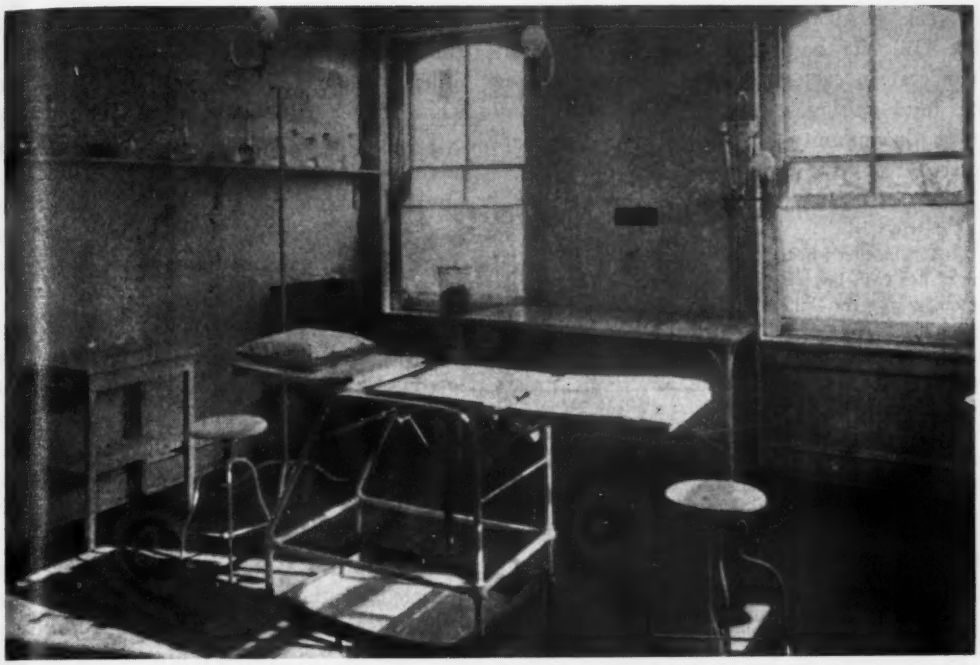
Compared to present standards the hospital of 1911 was primitive (Fig. II operating room and scrub up room), but of 263 surgical cases (nearly all major) and 109 medical (including forty-four typhoid) there were only twenty-seven deaths and ten of these were within the first forty-eight hours of admission. The lack of room and the physical impossibility of expanding the building gave concern to everyone interested.

One day, for lack of accommodation, we had to send home a case of acute appendicitis directly from the operating room, while the patient was still under an anesthetic. The patient recovered without incident, but a few complications in this case would have aroused more community agitation for a large building.

In 1913, the Auxiliary Board of Hospital Directors created the Board of Directors, and drives were started for money to pay for a new building away from the flimsy wooden structures in the middle of town. In May of that year a design for a new hospital was submitted to the Building Committee, but no decision was reached.

On August 26, fire broke out on Market Space adjoining the hospital. On all sides the cry went up, "Save the hospital. Save the patients!" The fire engine pressure failed, and the fire spread briskly out of control. The hospital laundry was in flames and the destruction of the building seemed certain. All of the patients were carried to safety, many as far as four blocks away. Reservoir water was turned into the town pipes, and men, women, and boys worked the hand pumps at the water station. All of the buildings adjacent to the hospital were destroyed but the hospital itself was saved, and a lesson had been learned.

An anonymous donor then offered a gift of $500 provided fifty others would contribute $200 each. A "Whirlwind" campaign was started to raise $40,000 for a new hospital. In



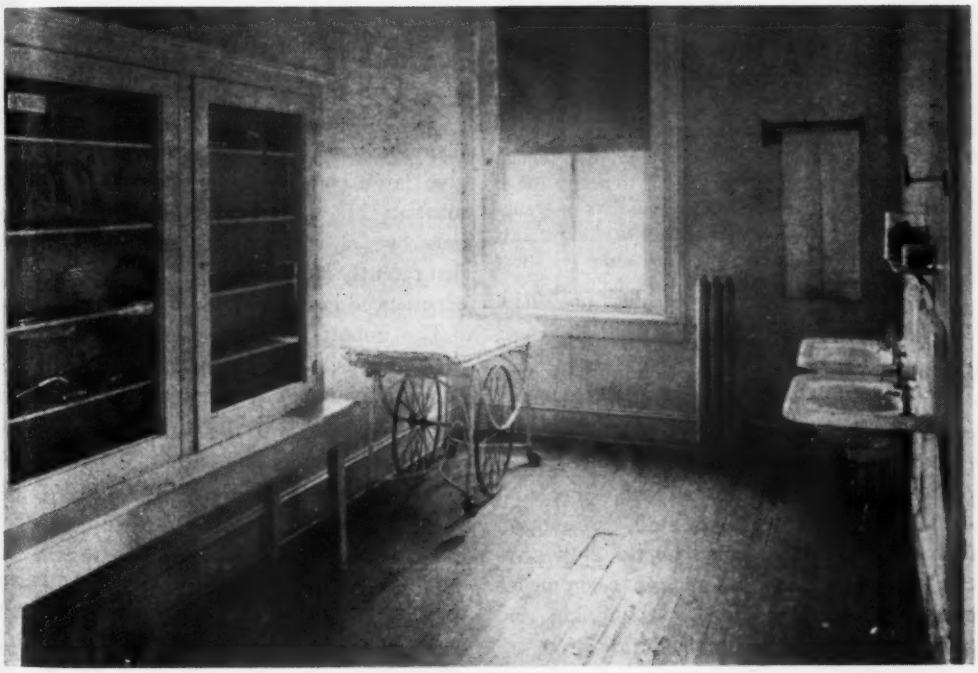


FIGURE II

six weeks $43,000 had been subscribed and the Oak Hill site had been donated. The Star-Democrat in each of its weekly issues during the fund raising campaign hammered away at the community conscience with its characteristic prose of the period."

A few excerpts to exemplify follow:

Easton mother's heart torn by accidental shooting of one of her twin boys through the abdomen. Boy saved by quick work of skilled physicians at the Emergency Hospital.

Not long ago a physician more than twenty miles from Easton rushed into a leading Centreville citizen's office saying he had a woman with an advanced case of appendicitis and peritonitis. The citizen's automobile was immediately placed at the service of the physician and the powerful machine sped through the darkness of the night on a race with death. Emergency Hospital was reached after midnight. Surgeon and nurses were in readiness, the operation was quickly and skillfully performed and the woman lives today.

A young woman performing on a trapeze in Chestertown fell . . .

An Oxford man was hurried to Emergency with his skull so badly fractured that his brains were oozing out.

Near Hillsboro a beautiful little four year old girl was kicked by a mule . . .

Emergency Hospital stands in our midst with doors open 365 days in the year, ready to minister to anyone who is injured or ill, without regard to race, religious belief, or whether able or unable to pay. But though demand has increased from 176 in 1907 to nearly 700 in 1913, there has been no increase in quarters or equipment. Many times it has been necessary to send patients home directly from the operating table while yet under anesthetic because of the over-crowded conditions.

The year 1914 was one of frustration. The Oak Hill site was returned to its donors because it faced the cemetery. The present site was purchased for $3750. On October 10, the Star-Democrat headlined the dissension between members of the board with each other and members of the board with the staff. A resolution had been passed and signed by the staff physicians urging the hospital directors to commence work immediately on the new building and stating that if this recommendation were ignored the physicians would petition the Governor. The physicians were of the opinion that construction must commence immediately in order to regain the confidence of the subscribers whose money had been donated over a year ago.

The Directors met on January 16, 1915, and advertised for bids for a three-story brick hospital. On March 13, the contract was awarded for $39,000. By May 29, the roof was on the hospital and the dedication ceremonies were held on November 23, 1915.

An appeal was made for donations of linen, pillow case tubing, table cloths and napkins, towels of all kind, bleached muslin for patient's gowns, canned fruits and vegetables. As usual, the response was enthusiastic.

Mr. & Mrs. J. W. Bigelow gave $1,000 for an X-ray machine. For the next few months, while Dr. William T. Hammond was completing special training, the machine was operated by the superintendent of the Easton Utilities (by good fortune the superintendent had been associated for three years with the electrical part of X-ray with the most prominent physicians in Paris). The hospital was now recognized to be the best equipped of any in Maryland outside of Baltimore.

Space does not permit a list of names of the many private individuals who were quick to give large contributions, but I would like to mention Mr. Milton Campbell, who was not only one of the earliest benefactors, but has just recently offered a radium unit complete with experienced radiologist.

The important fact was that everyone felt their responsibility and contributions were made either individually or in groups. A colored social club was one of the first to subscribe $100. The pupils of the first grade contributed $3. The employees of a small furniture factory gave $1,000. These, chosen at random, exemplify the widespread generosity which allowed the hospital on December 1, 1915, to have a balance on hand of $137.11 (including $3.50 received from the sale of the bath tub in the old hospital).

The basement contained an accident room,

dispensary, colored wards, laboratory, x-ray, drug and store rooms, kitchen, boiler, and servant's room.

The first floor contained male, female and children's wards, laundry, staff dining room, delivery room, nursery and maternity ward.

The second floor was to have had accommodations for twelve private patients, fourteen nurses' rooms and a nurses' sitting room, but from the day the hospital opened it was to remain so crowded that no nurse ever had a chance to use any of the so-called nurses' rooms. This gave a maximum bed capacity of fifty-five.

The operating rooms were on the third floor, but now the elevator was electric.

The year 1916 was chiefly of interest in preparing for emergencies in case of war. I remember that this was the year "Birth of A Nation" was shown in this town of approximately 3,000 population and drew a crowd of 1,339 even though the projection room caught fire one evening. It was also the year that the hospital acquired a certain distinction across the Mason-Dixon line when Mrs. Charlotte Varoter, a ninety year old cousin of Lincoln, was admitted for observation. This also was the year that the nurses, even while receiving the magnificent sum of $25 per week for twenty-four hour regular duty and $35 for contagion cases, began to talk of a possible twelve hour day.

During the war the hospital struggled along with a skeleton staff but even then it was apparent that more building must be done. The Talbot County Red Cross, whose drives had been so ably supported by the community during the war, found it had $20,000 remaining in the treasury. Believing that no finer use of this could be made than to help the community hospital, this amount was contributed in 1919 for the building of the Nurses' Home.

Benefit drives were begun in 1927 for the building of a separate maternity wing. Governor Ritchie, who was one of the first to send a check, helped lay the cornerstone at the dedication November 6, 1929, of the Mary P. Campbell building. Everyone was invited to the ceremonies and all who came were given a leaflet making a "pitch" for more contributions. If interest happened to flag as the afternoon wore on, this pamphlet was the only thing to read. The following excerpts from this leaflet will indicate practical applied psychology and also point out clearly the difference in hospital administration as it was then and as it is now.

A bright little boy, child of the poorest kind of parents, has been in the hospital for three months. He would have been dead two months ago at home. He is now well, fat, and happy. It costs $315.00. What is a boy's life worth in dollars?

A poor woman came in for her baby to be born—poor as poverty—husband a moron. Hanging to her skirts a miserable little boy of 5 years, ragged, underfed, sick, had to be taken in. After two weeks' treatment a home was found for him outside.

A 4 year old boy was severely burned when a kettle of boiling water fell upon him. He was treated at the hospital for nearly three months free of charge.

A young farmer who fell down a flight of stairs and suffered contusions of the brain, required two months' treatment, although he was only able to pay for three weeks' service.

A young man required a series of delicate abdominal operations. His occupancy of a hospital bed deprived his mother of her only means of support. When the hospital learned this, after he had paid his first weeks bill, further bills were suspended. A year later this young man paid his bill in full.

A business man suffered lobar pneumonia. He remained at the hospital seven weeks. It was found at the end of two weeks that his hospital bills seriously handicapped the expenses of his wife and children. Further bills were cancelled.

This woman owes her life and her baby son's life to hospital treatment. Hers was a difficult obstetrical case, which might have cost two lives without expert care.

These cases are merely typical of hundreds upon hundreds of others which Emergency Hospital has served in the twenty years of its existence.

As the physical plant increased to render service to the counties of Talbot, Caroline, Queen Anne's, and Kent, the active staff now consisted of two surgeons, four general practi-

tioners, a nose and throat specialist, and a roentgenologist-orthopedist; the associate staff numbered thirty-six. The concept of the hospital as an emergency institution was no longer valid. When we acquired a "grade A" hospital rating, and a certified nurses training school, the name was changed to the Easton Memorial Hospital in gratitude to the contributions of time and money of the many who had made this possible.

During the second World War the hospital struggled with a scarcity of medical personnel. Those of us who held the fort were delighted to welcome to the Staff the doctors as they returned from military service. The fame of the Eastern Shore and the recognized rating of a hospital of such high caliber appealed to many young as well as seasoned physicians from other states.

What physician does not like to have his own boat, to be able to fish or sail or get up in the middle of a freezing night in order to sit in a windswept duck blind with hope in his heart and numbness in his feet and hands? A delightful place for living, a growing community with an average per capita income of $1,693, and an exceptional hospital, made a combination that brought many applicants for staff privileges. The credentials committee limited all successful applicants to members who had passed their board examinations or were eligible candidates and well qualified general practitioners.

Post Second World War

The active staff consisted of three internists, nine surgeons, one each in pediatrics, radiology, pathology, opthalmology and obstetrics, seven dental consultants, and thirty general practitioners. There was now an abundance of medical talent but the hospital itself had in no way grown. The laboratory, which throughout the war had been maintained by one technician, now employed five, but in the same crowded space. Although the Junior Auxiliary and other organizations have kept the hospital supplied with superior equipment and have raised funds to grant any request of the staff from iron lungs and emergency electric generators to diathermy units and wheel chairs, the lack of plant space was appalling. To say that the hospital, which had enlarged its capacity more than 1,000 per cent over its original ability to care for the sick, was pressed for room would be an understatement. It is neither good for the patient nor the doctors to have beds in the corridors, but this was a routine situation.

Everyone realized that something had to be done, but there was a natural amount of inertia in the community. Finally, in 1951, under the dynamic leadership of Mr. George D. Olds, President of the Board of Directors, plans for a fund raising drive were laid. This was not so much by design a "whirlwind" campaign as that of 1913 was called. Speed was a factor, of course, but the amount was the grim determinate. There was a campaign to raise a fund that thirty years ago would have been regarded as fantastic. The goal in the "whirlwind" campaign had been $40,000. The goal in the 1951 campaign was to exceed $1,000,000. A Special Memorial Gifts Committee made a four month appeal to donors who desired to give a patient's room complete with furniture or a sun porch or an operating room in memory of some cherished member of their family. The local counties and their workers in Talbot, Queen Anne's, and Caroline required one month to cover the areas.

As is the custom here on the Shore, when the campaign was started and our people told of the need, they filled it with generosity and dispatch. In four months $1,130,000 was on hand or pledged. Almost everyone gave: people in the towns and on farms; fishermen; people who were retired; young people just getting started; members of the Board of Directors and, of course, the doctors.

The fund raising campaign was a big thing the year of 1951, and it was what everyone talked about. It was something the community realized spelled the difference between proper facilities for the increasingly complicated medical care

A view showing one of the beds in the recovery room in the new south wing

J. McKENNY WILLIS AND SON INC.
IN HONOR OF
J. McKENNY WILLIS SR.
IN HONOR OF
JOHN CHARLES THOMAS
THE BANKS OF EASTON
THE MAYOR AND COUNCIL OF EASTON

A portion of the lobby in the new wing

of the sky-rocketing number of new born; the multiplying numbers of the aged and the wide diffusion of the group between these extremes, and their present antiquated but well staffed hospital now bursting at the seams. So the fund was raised to build a new four story structure and to remodel extensively the old hospital. The campaign was completed on October 30, 1951, and the new building was dedicated May 15, 1955.

The people responsible for the planning of the old hospital of 1915 had had sufficient foresight to purchase five acres of ground; thus future expansion can be almost unlimited. Although not yet quite completed, the hospital of the near future will consist of five buildings as follows:

A new 4-story South Wing containing administrative offices, pharmacy, doctors conference room and library, snack bar, and main lobby on first floor. On the upper three floors are eighty-two private and semi-private beds, solaria, examining and treatment rooms, with a four bed surgery recovery room on the fourth floor.

A new North Wing containing modern kitchens on a single elevation, and a two story new 250 horsepower power plant as well as an emergency stand-by Diesel electric generating plant.

Remodeled old East, Center, and West buildings, three and four stories, containing eighty-two private, semi-private and pavilion beds, thirty bassinets in three nurseries, out-patient department, delivery rooms, operating rooms, pathology and clinical laboratories, X-ray department, fracture room, operating supply services, physio-therapy, school of nursing, mental hygiene clinic, staff dining rooms, and other facilities.

Other buildings: Maintenance shops and storage buildings; Pennsfield Student Nurses Residence.

Cost of total plant, including equipment and furnishings: $2,000,000.00

Total building area approximately 100,000 sq. ft.

Complement: 164 beds
30 bassinets
194 total

Full-time paid personnel—15 departments:

Hospital services	160
Faculty, School of Nursing	5
Total	165

Average student body—35

Annual payroll	$450,000.00
Other expenditures	350,000.00
Total (of this amount probably 70% finds its way into local channels)	800,000.00
Operating revenues	775,000.00
Approximate annual operating deficit	25,000.00

Type of hospital: Voluntary Non-profit Corporation.

Type of control: Volunteer Lay Board of Directors—18 members. Eight standing committees.

Medical Staff:

Honorary Medical Staff	2
Consulting Medical Staff	7
Active (voting) Medical Staff	33
Associate Medical Staff	4
Courtesy Medical Staff	12
	58*

Physicians According to Qualification:

College Fellow and Board Diplomate	7
College Fellow only	4
Board Diplomate only	10
Board or College eligible	4
General Practitioner	33
	58*
Courtesy Dental Staff (exodontia)	6

Physicians According to Staff Division:

Department of Medicine	5
Department of Surgery	14
Department of O.B.-Gyn.	2
Department of General Practice	33
Department of Pediatrics	1
Department of Radiology	2
Department of Pathology	1
	58*

* Includes Honorary and Consulting Staff members.

Staff Standing Committees: Credentials, Intern, Merit Award, Anesthesia, Operating Room, Record, Program, Tissue, Pharmacy, Joint Conference, Executive.

Hospital service area: Caroline, Queen Anne's and Talbot Counties, Upper Dorchester County, Lower Kent County. Population served, approximately 55,000.

Hospital memberships:
American Hospital Association

Maryland-D. C.-Delaware Hospital Association
American Association of Blood Banks
National Fire Protection Association
Other:
Registered American Medical Association
Fully Accredited by the Joint Commission on Accreditations of Hospitals
State accredited diploma School of Nursing
Training program for medical technologists approved by A.M.A.
Hospital Auxiliary—350 members

For the past 42 years one of the planks in nearly every governor's platform for election was an intention to build a bridge somewhere across the Chesapeake Bay. This threat had been hanging over the Eastern Shore for so many years that no one took it too seriously.

In 1952 Governor Lane's promise of a Bay bridge left the realm of political proposals to become a concrete and steel highway over which increasing thousands of motorists avail themselves of the easy access of travelling to our Shore. Until the bridge was completed the Eastern Shoreman travelled by ferry boat when he felt inclined to visit that part of the world west of Annapolis and Baltimore. The average opinion locally was that the bridge might hold together possibly three years or so, and it was with misgivings that we saw the ferries being sold. However, the bridge gives every evidence of continuing durability. Already it has brought so many changes on the Shore that there is an increasing awareness that for better or worse we have lost our isolation and are now attached to the mainland of the United States.

Progress (?) has come upon us with its motels, shopping centers, shore developments and subdivisions, improved roads and mounting highway deaths. As the community assumes its new form molded by the transient and permanent population it realizes its responsibility to the hospital for continued support and continued expansion. Compare the census of 1908 where 268 patients were admitted (101 absolutely free) to the first six months of 1955 during which period there were 2906 admissions!

There have been many applications for staff membership during the past year and each month brings more. A few new specialists and general practitioners have been accepted (not included in the previously mentioned statistics), but with the exception of a few departments, there is now no existing need for further increases.

The membership to the specialist division of the active staff is now practically closed because it is felt that the best interests of the community would not be served by a superabundance. Such a concept is something that in 1911 Dr. Hammond and I would never have dreamed practicable or ever necessary. However, in that day of the hand operated lift the idea of four automatic elevators would have appeared to be an hallucination.

Easton, Maryland

Talbot County Articles

RELATIVELY LONG TERM THERAPY OF STILL'S DISEASE WITH PREDNISONE (METICORTEN)

CASE REPORT

SHEPARD KRECH, JR., M.D.

Progressive rheumatoid arthritis of several joints, usually in symmetrical distribution, and accompanied by generalized lymphadenopathy and hepatosplenomegaly, seen in children is frequently designated as Still's disease. The disease is most commonly seen after the sixth year. Cases occurring in the eleventh month of life are extremely rare.

Prior to the advent of steroid hormone therapy in acute and chronic rheumatoid arthritis many of these children developed progressive, crippling deformities with flexion contractions, joint ankylosis, stunted growth, and terminal intercurrent infections.

METICORTEN (PREDNISONE)*

Prednisone (Δ1,4-pregnadiene-17A,21-diol-3,11,20-trione) a synthetic steroid hormone has recently been shown to exert a beneficial effect in rheumatoid arthritis, both as an anti-rheumatic and anti-inflammatory agent.[1, 2, 3] This hormone has recently been synthesized by Schering, and has been further shown to produce less-severe and fewer side effects than the other steroids. However, case reports of development of peptic ulcer, depressive organic psychosis and reduction in carbohydrate tolerance with use of prednisone have been published.[4] The occurrences of undesirable side-effects must be weighed against the therapeutic responses to the steroid hormones. Major opinion continues to feel that all steroids have limited value in the treatment of rheumatoid arthritis.

* The Prednisone used in this case was supplied as Meticorten by Schering Corporation, Bloomfield, New Jersey.

CASE REPORT

W.P. was first admitted to the Easton Memorial Hospital on November 12, 1951, at the age of fourteen months. He was born on September 14, 1950, the first of identical twins and weighed 5 lbs., 4 oz. at birth. His neonatal period and early growth and development were unremarkable. His present illness started at eleven months of age with bronchopneumonia for which he received a course of penicillin therapy. A week following cessation of therapy he developed a generalized dermatitis followed soon thereafter by progressive swelling of hands, knees, elbows and feet along with persistent daily pyrexia lasting approximately two months. Admission temperature was 104°, and the child had a diffuse maculopapular rash over face, trunk and extremities along with generalized lymphadenopathy, hepatosplenomegaly and polyarthritis involving fingers, hands, wrists, knees, ankles and feet. Laboratory examinations showed persistent secondary anemia, elevated sedimentation rates, negative blood cultures and negative febrile agglutinations. Electrocardiogram showed only sinus tachycardia. Lymph node biopsy was reported as hyperplastic lymph node showing a marked eosinophilic and leucocytic reaction. A diagnosis of Still's disease was made and the patient started on ACTH 15 mgm. q. six hours on November 17, 1951. Response was moderately satisfactory and he was maintained on this regimen until December 12, 1951, at which time he was switched to Cortisone because of recrudescence of fever and polyarthritis. He was discharged on December 24, 1951, on 80 mgm. Cortisone daily in divided doses, a clinically improved child.

He was readmitted on January 6, 1952 and again on

January 24, 1952 because of severe exacerbations of fever and polyarthritis. On these second and third admissions Cortisone was increased to 160 mgm. daily in divided doses, and the patient began manifesting symptoms of hypercortisonism, namely generalized edema, moon facies, rapid weight gain due to water retention and glycosuria. On January 31, 1952 he was transferred to Johns Hopkins Hospital where he was gradually taken off steroid therapy. Tonsillectomy and adenoidectomy was performed in April, 1952 followed by a course of radium therapy to the post nasal space. He was allowed home soon thereafter in a clinical remission, but joint deformities and flexion contractures of moderately severe degree persisted.

He remained in remission until December 6, 1953 when he again developed hyperpyrexia and acute polyarthritis. He was readmitted to Easton Memorial Hospital and hydrocortisone therapy in doses of 10 mgm. q. six hours was instituted. He was discharged on 30 mgm. hydrocortisone in divided doses daily on December 24, 1953. Sedimentation rate was still rapid and he continued running a low grade fever. Hydrocortisone was gradually decreased and finally discontinued in March 1954.

During the nine month period between March and December 1954, he remained in a clinical remission. He was able to follow a course of physical therapy three times weekly, manifesting gradual return in functional muscle strength. On January 4, 1955 he developed an upper respiratory infection, pharyngitis and return of joint pains. He was placed on a tetracycline without any response, and his polyarthritis became worse. He was readmitted to Easton Memorial Hospital on January 11, 1955 critically ill, in a semi-moribund state, and running a temperature of 105°. Physical examination on this admission revealed a generalized maculopapular eruption, generalized lymphadenopathy, hepatosplenomegaly and Heberdon's nodes over both olecranon processes. All involved joints were markedly swollen, tender and acutely inflamed. Aside from supportive therapy he was given 10 mgm. hydrocortisone every four hours for twelve days without any noticeable change. On January 23, 1955, hydrocortisone was discontinued and ACTH gel 20 mgm. daily was initiated. The rash and polyarthritis gradually subsided but he continued to run a febrile course; he received several small transfusions for his anemia and concurrent supportive therapeutic measures. He continued to remain a critically ill, apathetic child, and on February 1st, 1955 Dr. Edward Henderson of the clinical research division of Schering Laboratories was consulted with the idea of placing the patient on Prednisone. This company very graciously supplied us with the drug which was started on February 15, 1955 in dosages of 2.5 mgm. q. six hours and increased to 5.0 mgm. q. eight hours three days later. This dosage was maintained until March 21, 1955 at which time it was reduced to 5 mgm. q. twelve hours. Twenty-four hours following the initial institution of Prednisone therapy the patient became afebrile and was able to play in his crib for the first time in six weeks. Joint swelling regressed rapidly and appetite and general well-being increased markedly. He was discharged afebrile on February 28, 1955 and referred back to physiotherapy department for reinstitution of joint muscle rehabilitation. Maintenance dosage of Prednisone was gradually decreased, and on August 1, 1955, he was placed on 2.5 mgm. daily on which he has been maintained to date.

Evaluation of this child's response to Prednisone therapy places him in Steinbrocker's Therapeutic Grade 1, Complete remission 5. There are at present no objective findings of joint inflammation and no systemic signs of rheumatoid activity, either intra or extra-articular. Joint mobility is not impaired, other than that associated with the irreversible changes of the chronic disease itself. Erythrocyte sedimentation is normal.

The child at the time of this report is able to pursue a relatively normal life with very few residual handicaps. He continues to receive vigorous physical therapy three times weekly and manifests very little objective fatigue when compared with his twin brother. He has demonstrated no evidence of hypercortisonism since he has been on meticorten therapy, either clinically or biochemically.

Discussion

This case was not originally selected to evaluate the response to meticorten. In view of Bunim's timely report of this new steroid[1] at the time this patient was most ill it was felt that Prednisone, although then not available for general use, should be tried.

The anti-inflammatory and anti-rheumatic effects of small doses of Prednisone are most striking. When compared with ACTH and hydro-cortisone it appears to be four or five times more potent. Functional improvement was extremely rapid with Prednisone, whereas moderate doses of the other two steroids failed to produce any noticeable clinical changes. No symptoms or signs of meticorten toxicity were seen on the dosage schedule outlined in this case report. The dosage of prednisone used was

small, and the maximum tolerated amount was never ascertained.

Most important, however, was the rapid production of a state of remission, so that the child could be started on vigorous physical therapy, thereby tentatively avoiding permanent flexion deformities.

No conclusions can be reached regarding the effect of this steroid upon the progression of the pathological process of rheumatoid arthritis. Total duration of therapy has been six months, an insufficient period of time in which to judge any beneficial alterations of the rheumatoid process in a single child.

Summary and Conclusions

A case of Still's disease treated for a period of six months with Prednisone (Meticorten) is presented. This steroid was found to have a very marked anti-inflammatory and anti-rheumatic activity in small doses. The undesirable side effects of these hormones is mentioned. No conclusions can be reached relative to this hormone influencing the pathological process of rheumatoid arthritis in a child. Signs and symptoms of hypercortisonism were lacking on the small dosage schedule used in this case.

The child has been completely off Prednisone for five months and remains in a complete clinical remission as of February 10, 1956.

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RHABDOMYOMA OF THE HEART

CASE REPORT

EDWARD C. H. SCHMIDT, Ph.D., M.D. and KURT LEDERER, M.D.

Tumors of the heart are one of the more uncommon conditions encountered in sudden deaths of infants, and this is even more unusual in newborns. The presence of a rhabdomyoma of the heart in a sixteen day old infant seems worthy of report.

Case Report

This sixteen day old colored female infant was delivered spontaneously following an uneventful pregnancy. The mother was a twenty-nine year old intelligent, well-developed woman who had no known pathologic condition. The thirty-eight year old father is in good health. Both father and mother are Rh positive. There is no known history of cardiac or other congenital anomalies in either family.

The infant was examined following delivery and appeared to be in excellent condition with normal heart and breath sounds. On the fifteenth day of life, one day before its demise, the child appeared to have slight difficulty breathing, but did not appear in acute distress. The temperature was normal. The following morning the child was brought to the doctor's office dead. The parents stated that she had become worse during the night.

Autopsy

The body was that of a female colored infant measuring 39 cm. in length and weighing 2975

grams. Examination of the head was not remarkable except for a small quantity of mucoid material which could be seen in the back of the mouth and in the nasopharynx. The skin was of normal uniform color. The bone marrow of the sternum was pale. The liver extended 4 cm. below the costal margin in the mid-clavicular line. There was approximately 20 cc. of clear fluid in the peritoneal cavity. The thymus was small and resided in the upper portion of the mediastinum. There were a few petechiae on its anterior surface.

The pericardial sac occupied approximately two-thirds of the transverse diameter of the chest. There were 5 cc. of clear fluid in the sac. The great vessels were of normal distribution. The heart weighed 60 grams and was quite globular. The left ventricle was tremendously dilated and there were a few white areas beneath the epicardium of the right atrium. These white areas appeared to be sub-epicardial depositions of white tissue. There were five of these nodules present. The smallest measured 1 mm. in diameter and the largest measured 5 mm. in diameter. There were scattered petechiae along the atrioventricular sulcus on the right side of the heart. In one area of the myocardium in the left ventricle, there was a creamy white area which was oval in shape and measured 15 by 14 mm. There was a rounded nodule near the base of the right ventricle which measured 18 mm. in diameter and was slightly raised above the surrounding surface of the myocardium. On opening the right side of the heart, the endocardium in both the atrium and ventricle was seen to be smooth and of a normal color. The valve leaflets were delicate. At the base of the lateral leaflet of the pulmonary valve, there was a firm round nodule measuring 3 mm. in diameter which appeared to be in the myocardium. The pulmonary artery was of normal configuration. The ductus arteriosis was widely

FIG. 1. External view of the heart showing numerous pale areas and the nodule at the apex.

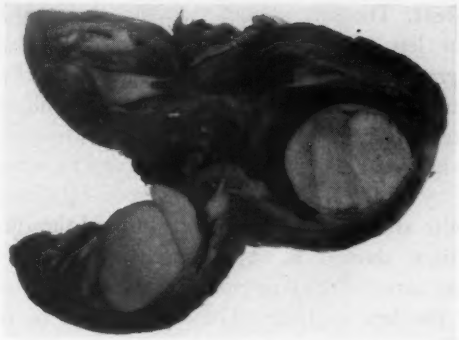

FIG. 2. The heart opened showing a large nodule which has bisected and numerous smaller nodules in the myocardium.

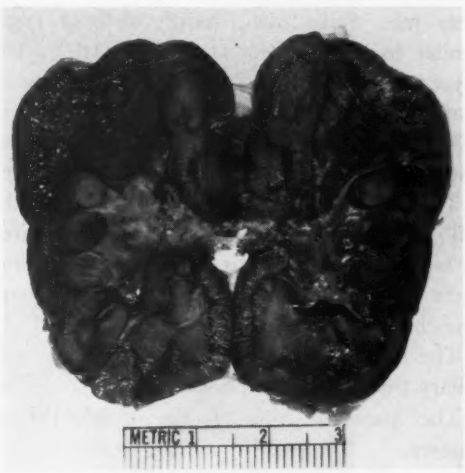

FIG. 3. Section of the kidney showing two areas of cysts

patent. The left atrium was not remarkable. The left ventricle was markedly dilated and there was a smooth rounded nodule projecting into the ventricle which appeared to be in the lateral posterior wall and on section proved to be an ovoid mass which was white and measured 29 by 21 by 24 mm. Sections through the small white areas beneath the epicardium of the right atrium showed a white character similar to that noted in the larger mass in the myocardium of the left ventricle. The myocardium of the right ventricle measured 5 mm. in thickness. There was a small nodule at the apex of the right ventricle which measured 12 by 11 by 14 mm. This was white with sharply defined edges similar to that seen in the left ventricle. The myocardium of the left ventricle measured 8 mm. in thickness. The valve rings measured in millimeters: tricuspid, 34; pulmonary, 28; mitral, 36; aortic, 18.

The right lung weighed 36 grams and the left lung weighed 29 grams. There appeared to be minimal atelectasis of the right lung and there was a small amount of clear fluid in both bronchi.

The liver weighed 108 grams. The liver and biliary tract were not remarkable.

The pancreas showed the usual lobular pattern.

The spleen weighed 15 grams and was enlarged in relation to the other organs.

The adrenals showed the usual infantile appearance.

There was marked fetal lobulation of the kidneys which weighed 30 grams together. In the upper lateral third of the right kidney, there was a poorly-defined nodule laying beneath the capsule which measured 18 by 25 by 10 mm. This raised the capsule and appeared to be an intimate portion of the cortex. This nodule was sharply demarcated from the remaining portions of the kidney and appeared to have a vacuolated pattern. There were a few yellow stria in the papillae.

The cerebrospinal fluid was clear and glistening and multiple sections through the brain did not reveal any abnormalities. The pituitary was of average size.

Microscopic Examination

Section of the large nodule in the left ventricle showed a tumor composed of a fibrillary network; which, in many areas contained large pale cells with round nuclei in the centers and with fine processes extending from the periphery of the cells. These resembled so-called "Spider cells." In other areas, there were large cells with cytoplasmic granularity suggestive of striations. At the periphery in some areas, the tumor was sharply demarcated from the myocardium while, in other areas, the boundary of the tumor was indistinct and muscle cells appeared to blend with tumor cells. The larger blood vessels in the tumor were surrounded by a layer of fibrillary fibrous tissue which appeared to follow many of the small blood vessels. Even the capillaries were distinct from the tumor elements. A section taken through the atrium showed the small white nodules to have a similar pattern. In the right ventricle, one portion of the wall of the myocardium was completely replaced by tumor. The cellular pattern in these tumors was distinct; and, in some areas, it had an almost cystic or angiomatous embryonal appearance. The tumor did not appear to involve the epicardium in any sections.

The nodule in the right kidney showed multiple large tubular cysts lined by tall pale acidophilic epithelium. In several of these, glomerular-like structures projected into the cyst. In a few foci, the lining cells appeared to be piled into small papillations. The glomeruli of the surrounding kidney parenchyma were infantile, but otherwise not abnormal.

Various sections through portions of the brain did not appear remarkable. The various layers of the cortex and white matter were distinct.

The liver cords were widely separated; and in areas, the basement membrane of the sinusoids appeared separated from the liver cells suggesting edema.

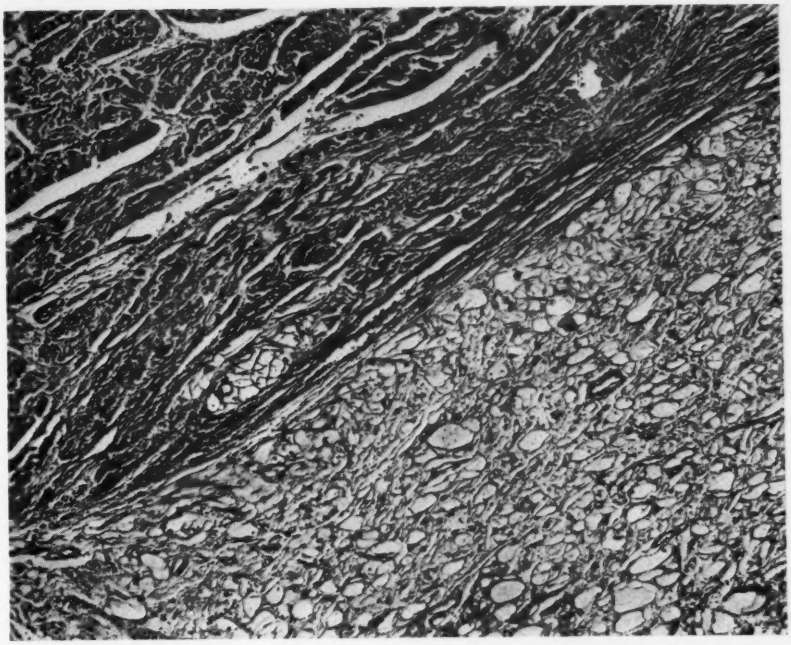

FIG. 4. Photomicrograph of the edge of the tumor showing the relatively intact myocardium and the large tumor cells in the lower right portion.

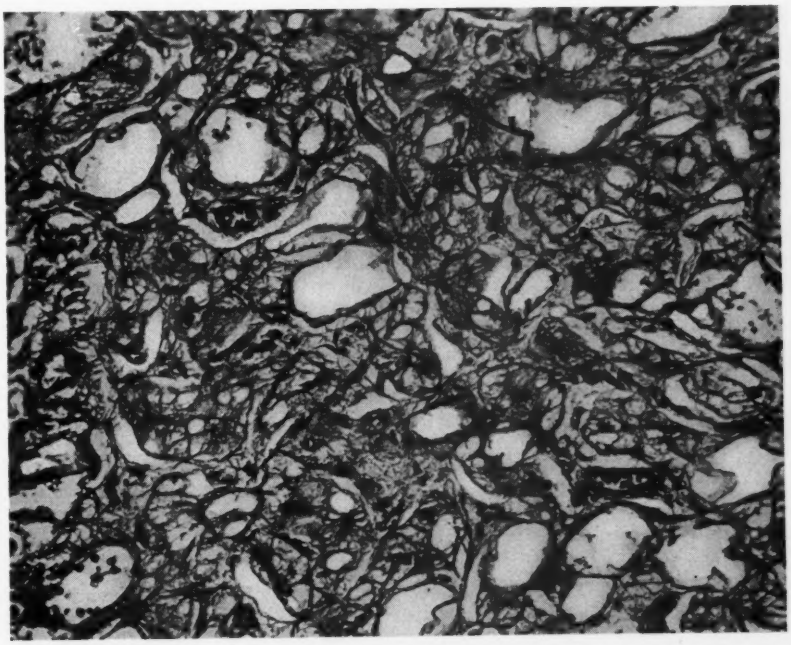

FIG. 5. High power magnification showing larger vacuolated cells and a typical "Spider-Cell" in the center

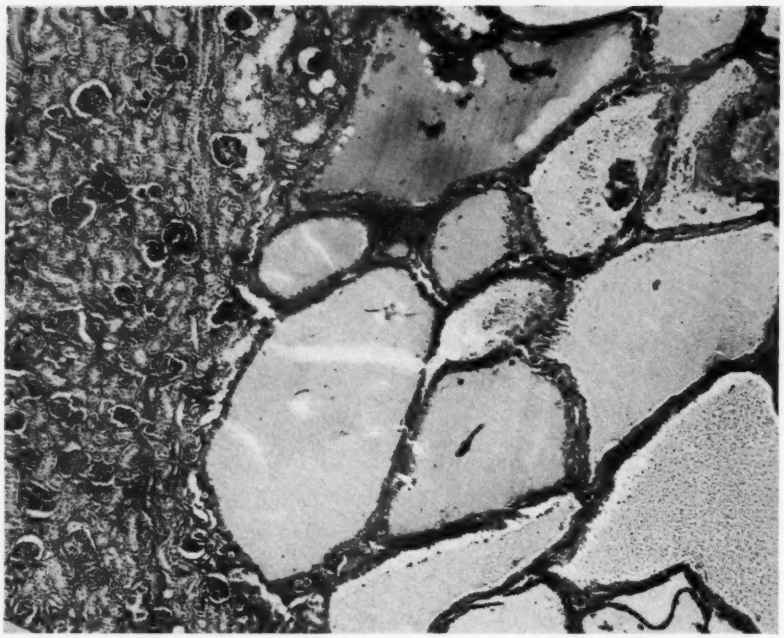

FIG. 6. Low-power view of the edge of the tubular adenoma of the kidney

COMMENT

In a review of cardiac tumors, Pritchard stated that approximately seventy rhabdomyomas of the heart have been reported. Since the true status of rhabdomyoma is difficult to establish, this type of tumor has been confused in the past with many other conditions which are unrelated to primary rhabdomyomas of the heart. Also the terms "glycogenic tumor" or "congenital nodular glycogenic degeneration" have been applied to this tumor. Some of the reported cases have been confused with other degenerative diseases. By some, they have been considered a hamartomatous defect. The fact that these tumors enlarged or degenerated into rhabdomyoma-sarcoma has not been observed.

The origin of these tumors has been discussed at some length by Farber in a comprehensive review of the cases published up to 1931. In this paper, Farber concluded that "the evidence seems to point against a true neoplastic nature of this growth" and believed that they should be considered hamartomas until the origin is further clarified. In the studies of the subject others have considered origin from Purkinje fibers, primitive cells from which both the conductive system and the myocardium are derived, degenerative muscle fibers or embryonic rests.

Eighty per cent of these tumors occurred in children under five years of age. Forty per cent of the patients died before reaching the age of six months and an additional twenty per cent of the patients died before their first year of life. The oldest recorded patient with rhabdomyoma was forty-five years of age. The close association of these tumors with tuberous sclerosis has been noted by practically all authors. Below the age of six months, approximately one-third of the cases have shown tuberous sclerosis; whereas, in the older age group tuberous sclerosis is found in a much higher percentage of the patients; and in those patients dying between five and fifteen years of age it was found in one-hundred per cent. It may be that the rhabdo-

myoma is a part of the same disease process which produces tuberous sclerosis and has not sufficiently developed in the patients which die very early in life; or it may be due to the fact that the brains of the younger patients have not been as thoroughly examined as those of the older patients. Rhabdomyomas may occur in any portion of the myocardium and have been found in practically all areas of the heart. Sudden death is the usual mode of exit in these patients and cyanosis may be practically the only sign prior to death. The patients with tuberous sclerosis frequently show neurologic symptoms characteristic of this condition. Approximately half of the cases with cardiac rhabdomyomas show defects of the kidney which are for the most part cystic tumors and in many cases, apparently represent early stages of polycystic disease.

SUMMARY

A case of congenital rhabdomyoma occurring in a sixteen day-old colored female who died suddenly is reported. This condition was associated with tubular adenomata of the kidneys, but without evidence of tuberous sclerosis.

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BENIGN PULMONARY LESIONS SIMULATING MALIGNANCY*

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The problem of benign pulmonary lesions simulating malignancy is with us and will continue to be an enigma until we can increase our diagnostic facilities and acumen and eventually better pin-point, without operation, just what these lesions are. At present, it is not unusual for a pulmonary lesion to require thoracotomy and biopsy to determine its nature (malignant or otherwise) even though one utilizes all available diagnostic studies.

In as much as solitary, circumscribed pulmonary lesions (coin lesions) are malignant in fifty per cent or more cases in people past fifty years, it is generally agreed that thoracotomy and biopsy are necessary in these lesions otherwise we cannot diagnose them definitely. Just as we must be well versed on malignant pulmonary lesions, so must we, be equally well versed on benign pulmonary conditions. As previously stated, in about fifty per cent of cases having coin lesions, we are going to be dealing with non-malignant entities, and, therefore, we must be prepared to deal with the disease at hand.

The following cases are presented to further illustrate the problem and to show from a practical standpoint, how difficult it is sometimes to differentiate operatively as well as preoperatively benign from malignant pulmonary lesions.

* These cases are from the files of the USPHS Hospital, Baltimore, where the Author previously served as Deputy Chief of Surgery.

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Case #1. WPD

This fifty-eight year old white male was asymptomatic and was sent into the hospital for evaluation of a lung nodule picked up on a routine chest x-ray. This lesion was noted elsewhere two and one-half years prior to the time of the patient's admission, and a diagnosis of suspected neoplasm was made. The patient had not been notified of the previous finding and, therefore, had not been treated.

His admission examination was negative except for the presence of an upper cervical esophageal diverticulum. Routine laboratory tests were normal. Skin tests were as follows: purified protein derivative positive; coccidioidin positive; blastomycosis negative; histoplasmosis negative. Complement fixation tests were as follows: coccidioidomycosis negative; histoplasmosis negative; blastomycosis negative. Cultures were as follows: sputum times three were negative for acid fast bacilli. Sputa times two were negative for fungi. Guinea pig innoculation negative. On August 9, 1954 the patient had an esophageal diverticulectomy which was uneventful. Three weeks later he had a right thoracotomy and wedge resection of the lung which was declared benign at frozen section. Postoperative course was uneventful, as well as a one year follow-up examination. Microscopic diagnosis by Armed Forces Institute of Pathology was coccidioidomycosis.

Case #2. WCN

This forty year old white male seaman was admitted asymptomatic but with a diagnosis of a solitary lung nodule picked up on routine photofluorogram. Previous yearly photofluorograms had been normal. Past history and physical examinations were negative. Laboratory tests: sputa cultures times three were negative; sputa examinations times four for acid fast bacilli were negative; bronchial washings were negative for malignant cells. X-ray revealed an infiltrative lesion in the right first interspace with a central area of rarefaction. Skin tests: purified protein derivative negative; coccidioidin negative; histoplasmin skin tests positive; blastomycosis positive. Complement fixations for histoplasmosis times two were negative.

Hospital course: Bronchoscopy was negative. The patient was evaluated in chest conference and by the tumor service and it was felt that thoracotomy was indicated with a most likely diagnosis being carcinoma, in view of the presence of a coin lesion and a negative purified protein derivative test. At surgery, the lesion was in the upper lobe well circumscribed but not encapsulated and on cut section it was dense and fibrotic. Frozen section showed only granulomatous disease. A right upper lobectomy was done. Postoperatively, the patient was placed on streptomycin and isonicotinic hydrazide and subsequently allowed to go home to continue treatment at home. The pathological diagnosis was tuberculosis. The patient has remained asymptomatic postoperatively.

Case #3. CW

This forty-five year old white female was transferred from a Pittsburgh Hospital with a diagnosis of fever of unknown origin. She had been admitted there for anorexia, headaches, chills, fever and malaise, and right upper quadrant pain. Examination on admission was essentially negative. Laboratory data revealed a white count of 13,000 with a shift to the left; sedimentation rate 45. Routine agglutinations were negative; complement fixation for amebiasis was negative. Liver function studies were normal; stools negative. X-rays revealed an elevation of the right diaphragm with an infiltrate just above the height of the dome with some obliteration of the right costo-phrenic sinus. Serial x-rays showed early resolution of a lung lesion and an underlying granulomatous process was suggested. Tomograms six weeks after admission showed a fairly circumscribed lesion in the right middle lobe. Complement fixation for coccidioidomycosis and histoplasmosis were negative. Skin tests: purified protein derivatives were negative in first and intermediate strengths and questionably positive on the second strength; histoplasmin was positive; blastomycin was positive.

Hospital course: She became afebrile the day after admission and remained so. Bronchoscopy was not remarkable. Bronchial washings were negative for neoplastic cells. The patient was seen in consultation by the surgical service and thoracotomy was advised in view of the strong possibility of malignancy since the lesion had failed to resolve. A subsequent x-ray report gave the impression of a probable granuloma or neoplasm of the right middle lobe whereas the early impression had been that of a resolving pneumonia. The patient was quite emotionally upset. She went home for a three week period and returned for a thoracotomy at which time a wedge resection of the 1.5 centimeter granulomatous lesion in the middle lobe was carried out. Grossly it showed cavitation with a purulent center. Postoperatively, the patient was placed on streptomycin therapy until fungi and tuberculosis cultures were reported negative. Microscopic diagnosis by Armed Forces Institute of Pathology was histoplasmosis.

Case #4. SK

This thirty-three year old white male was admitted with a tentative diagnosis of mediastinal neoplasm. His present illness began about two weeks before admission

when he was awakened by severe pain beneath the right scapula. It lasted three days, and he developed malaise and generalized aching. The chest x-ray revealed enlargement of the mediastinal shadow on the right side. White count revealed a leukocytosis and the patient was treated with aureomycin and penicillin which produced only a remission of the scapular pain. His past history and review of systems were negative. Physical examination on admission was not remarkable. Laboratory data were essentially normal. Complement fixation for amebiasis was negative. Complement fixation for histoplasmosis was negative. Purified protein derivative in three strengths was negative. His x-rays on admission revealed an area of increased density in the right peribronchial area. Subsequent examinations revealed hazy infiltration through the first, second and third interspaces. Tomography revealed narrowing of the upper lobe bronchus at its division from the main lobe bronchus.

Hospital course: The patient ran a low grade febrile course. He was bronchoscoped with nothing specific being found. Following bronchoscopy be had some hemoptysis with an increase in daily fever spikes. Following bronchoscopy there was noted an infiltrate in the periphery of the right upper lung field. The patient was put on terramycin therapy and was subsequently seen in tumor conference and chest conference, and it was felt that the diagnosis rested between bronchogenic carcinoma with extension to the mediastinum or a malignant lymphoma. Thoracotomy was carried out and the right lung was found adherent to the chest wall over a small area of the lateral portion of the upper lobe. These adhesions appeared recent, being friable and vascular. A semi-solid mass was present in the posterior segment of the upper lobe and appeared to be inflammatory. Biopsies from this region on frozen section revealed chronic pneumonitis. In addition, there was a firm mass arising in the middle portion of the upper mediastinum and this lay lateral to the superior vena cava and extended into the right lung root. It had the appearance of a chronic inflammation and was densely adherent to all surround structures including the vena cava. There were no other findings suggestive of metastatic nodes. The chest was closed without pulmonary resection of any type. The subsequent microscopic diagnosis was organizing pulmonary infarction and fibrosis of hilar lymph nodes. Subsequently the patient has been evaluated on several occasions and the peripheral infiltrate has subsided but he still maintains some increased density in the mediastinal area and has returned to his normal activities.

Case #5.

A thirty-two year old white female who in November, 1950 had a low grade fever, with stabbing pain between the scapulae and a dry cough. She was treated elsewhere for three weeks for what was thought to be a virus pneumonia. She had a recurrence of her symptoms in January, 1951 and further films were taken and a diagnosis of tumor in the left lung was made. She had a normal physical examination on admission except that she was pregnant. Laboratory examinations were normal. Skin tests and complement fixation for blastomycosis were negative. X-ray of the chest on March 12, 1951 showed a marked density extending upward and somewhat outward in the upper section of the root of the left lung. Bronchoscopy was negative. Thoracotomy was performed on March 29, 1951 and a seven centimeter sized mass was found in the upper part of the lower lobe. This lesion extended to a depth of about one centimeter into the lung and was attached to the chest wall between the fourth and fifth ribs. The central portion of the tumor was necrotic. A piece of the tumor was removed for biopsy and the chest closed with the impression of it being an inoperable carcinoma of the lung. Microscopic report and subsequent culture revealed blastomyces dermatitidis. The patient was treated postoperatively with aureomycin, penicillin and stilbamidine. She improved under treatment. She was discharged on June 14, 1951 and x-rays at that time revealed complete regression of the lesion. On November 4, 1951 the patient delivered a living female child. Final diagnosis was pulmonary blastomycosis.

Case #6.

A forty-nine year old white male seaman was admitted for evaluation of a coin lesion of the left lung. The history revealed weight loss of sixteen pounds in four months with a chronic cough productive of a slight amount of clear sputum and no other pulmonary symptoms. Chest x-ray and G-I series two years previously had been normal.

Physical examination was negative except for some weakness of muscles on the right side of the body with some atrophy and increased deep tendon reflexes. Hoffman and Babinski reflexes on right side were positive.

Laboratory data: Routine tests normal. Complement fixation for histoplasmosis was negative, but the skin test was positive. Skin tests for other fungi were negative as was the purified protein derivative test. Sputa were negative for acid fast bacilli and fungi. Bronchial washings were negative for malignant cells. Tomograms revealed a coin lesion in the third left intercostal space anteriorly without calcification.

Hospital course: Bronchoscopy was normal. Biopsy of a left axillary lymph node was not diagnostic. Thoracotomy revealed a lesion of the upper lobe which was excised and diagnosed microscopically as hamartoma. The post operative course was uneventful.

SUMMARY

Six case reports are presented each being a benign pulmonary condition, but each showing characteristics so similar to malignancy that thoracotomy and biopsy were deemed necessary. One coin lesion was a tuberculoma, even though accurately performed purified protein derivative tests were negative; another case was active blastomycosis in which complement fixation tests and skin tests were negative; another coin lesion was a focal area of coccidioidomycosis; whereas another was a hamartoma. Still another lesion appeared preoperatively as a malignancy but was a vague mediastinitis and pneumonitis. Another lesion which failed to resolve in a six week period and was suspicious of carcinoma of the lung was histoplasmosis with a negative complement fixation, but a positive skin test.

We have found it not uncommon, in our practice, that a suspected tumor preoperatively is, at surgery, a disease far removed from the realm of neoplasia. We have found that this has made the field of tumor therapy much more challenging and stimulating academically, for we must deal with a multiplicity of diseases other than neoplasms and must constantly broaden our knowledge in this field.

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IATROGENIC JAUNDICE

CHARLES H. WINNACOTT, M.D.

During the past several years, there have appeared in our journals and periodicals many articles on iatrogenic disease with its various complex ramifications. It is not a new concept as an etiological factor in explaining many of the symptom complexes presented by our patients. However, as with functional illness, its importance is perhaps not fully realized in the management of our patients. We will all admit that it should be uppermost in our minds at all times because of the very meaning of the term "iatrogenic disease." Briefly, for the purpose of clarification and review, a short statement as to what is meant by this term is indicated. Iatrogenic disease is disease, organic or functional produced directly or indirectly by the attending physician. It is not the purpose of this paper to go into detail regarding all the complexities of iatrogenic disease, but merely to discuss one aspect of the subject and the problems presented to both physician and patient. This aspect of iatrogenic disease will be that of an obstructive type jaundice induced as a result of the toxic effects of one of the newer drugs now commonly used.

Thorazine* is a drug which has recently been introduced to the profession for the treatment of the widespread mental and emotional disturbances found in every day practice. It has a selective inhibitory action on the central nervous system, particularly in psychomotor and emotional functions.[1] It has been particularly valuable in treating patients with mental disturbances from the range of the mildly upset, tense, anxious patient whom we all see to the severely disturbed, psychotic patient whom the psychiatrist sees. In addition, it is found to be extremely valuable in treating nausea of pregnancy, postradiation nausea, postoperative nausea, and potentiating the various narcotics used for pain in the terminal cancer patient, and various other uses.[2]

It follows that here is a drug which will be used widely by the general practitioner, internist, psychiatrist, surgeon, and obstetrician.

* Thorazine—S.K.F.'s Brand of Chlorpromazine.

It is expedient, then, that we become acquainted with its common toxic or untoward effects. One such effect is jaundice of the obstructive type. This jaundice is apparently caused by blocking of the biliary canaliculi due to stasis of bile with no resulting liver damage. This has been confirmed by all laboratory studies to date on reported cases of Thorazine-induced jaundice. However, this iatrogenic jaundice, even though studies indicate that the incidence is below one per cent and is transitory with apparently no permanent organic damage, is not so innocuous as it appears on the surface and cannot be passed over lightly. It presents another difficulty in the already complicated "differential diagnosis of jaundice."

Herein will be presented two cases of jaundice occurring in patients receiving courses of Thorazine. Although the resulting jaundice in each case subsequently proved to be transitory, it will be seen that an interesting situation developed in comparing the two cases as well as several serious and anxious moments for both physician and patient.

Case 1. This is a case of a forty-two year old, white, married female who was admitted to the Easton Memorial Hospital November 7, 1954 complaining of nausea, vomiting, right upper quadrant fullness, and jaundice. At the time of admission, she was not acutely ill, however, she exhibited generalized jaundice and was unable to tolerate fluids by mouth.

Present illness dated back to about twelve days earlier with symptoms of upper respiratory infection. During the next five days, she was placed on a regimen of bedrest, soft diet, and aspirin with subsidence of symptoms. However, on November 5, 1954 she complained of right upper quadrant fullness, nausea, and slight vomiting and one day later became jaundiced with elevated temperature (101.4). She was admitted to the hospital the next day with a tentative diagnosis of Jaundice due to Thorazine with infectious hepatitis to be ruled out.

During the preceding six months, the patient had been complaining of generalized neurasthenia, irritability, anxiety, tension, and periods of depression. She had been unresponsive to the usual sedatives and psychotherapy. She was finally started on Thorazine mg. 25 q. 4 h. October 4, 1954 with marked improvement and finally complete disappearance of symptoms. Dosage was reduced at the end of ten days to mg. 10 q. 4 h. and continued until November 6, 1954.

Past history was essentially negative; gravida 3, all pregnancies uneventful, no surgical operations, no blood transfusions, and no gall bladder history.

Physical examination at the time of admission revealed a well nourished, forty-two year old female exhibiting generalized icterus, moderately severe, but not appearing acutely ill. Positive findings; generalized icterus, scattered, small, discrete, anterior cervical and axillary nodes; moderate tenderness right upper quadrant. Remainder of physical examination was essentially negative.

The usual routine laboratory procedures, serology, hemoglobin, red blood count, blood chemistry (blood urea nitrogen, glucose, and creatinine), were negative. Prothrombin time was 15 seconds (normal 15 seconds). Subsequent prothrombin determinations were essentially within normal limits. Bile was present in the urine at the time of admission, but had disappeared on hospital discharge (November 24, 1954). Leukocyte count revealed slight leukopenia with slight increase in lymphocytes. Sedimentation rate was slightly elevated.

Pertinent laboratory data in regard to the type of jaundice were as follows: Icterus index elevated; serum bilirubin elevated 11.5 mg. per 100 cc., with 1 min.: 4.5; 30 min. 7.0 mg. per 100 cc.; alkaline phosphatase within normal limits; cholesterol normal; thymol turbidity 2.2 units (normal 0.5 units); cephalin flocculation slightly positive; total serum proteins 6.65 gm. per 100 cc. of serum, 3.5 gm. of albumin, and 3.15 gm. of globulin.

Patient's course was one of gradual improvement on a conservative medical regimen of absolute bedrest, intra-venous glucose and high caloric diet, multivitamins, and mild sedation (phenobarbital gr. ¼ twice a day). By November 18, 1954 clinical jaundice had subsided and patient was feeling fine. At this time, laboratory studies were approximately normal. Gall bladder visualization revealed a normal functioning gall bladder. Prior to discharge, all liver function tests were within normal limits. Patient was discharged November 24, 1954 and has remained asymptomatic.

Diagnosis: Infectious hepatitis.

Case 2. This is a case of a sixty-six year old, white male admitted to the Easton Memorial Hospital March 5, 1955 with sudden onset of jaundice, chills, fever, epigastric fulness, and nausea, but no vomiting.

During the preceding six months, he gave a history of generalized neurasthenia, anxiety, and depression. He

had been worrying considerably over his inability to carry on full time farm activities. Because of a mild coronary thrombosis in the Spring of 1954, he had been curtailed in his usual sixteen to eighteen hour a day farm activities. His temperament was such that in spite of reassurance that his condition was excellent for his age no adjustment was made to a change in his living habits. During this period, there was no weight loss, appetite remained good, no specific gastro-intestinal symptoms; in other words, there were only non-specific functional complaints. About March 25, 1955, he was started on Thorazine mg. 10 T.i.d. However, four days later he developed symptoms of an acute gastroenteritis with nausea, vomiting, diarrhea, chills, fever, and generalized myalgia. It was believed at this time that he probably had an acute viral infection. Thorazine was stopped and never resumed. He responded within four days on a conservative regimen of bedrest, fluids, and Cremosuxidine. However, on April 4, 1955, he developed jaundice, chills and fever, and nausea. He was hospitalized April 5, 1955, with a tentative diagnosis of infectious hepatitis. With toxic jaundice due to Thorazine, to be considered in the differential diagnosis.

At the time of admission, he exhibited no acute distress, but was quite apprehensive over his generalized jaundice, abdominal tenderness, and the possibility that he might have cancer (suggested by apprehensive family).

Physical examination revealed an elderly male exhibiting moderate generalized icterus, elevated temperature (101.4), and a somewhat distended upper abdomen, with right upper quadrant fulness and tenderness. Remainder of physical examination was essentially negative.

Laboratory examinations: Urine dark brown in color, positive for bile. Stools light, almost clay colored. Complete blood studies, hemoglobin, and sedimentation rate normal. Serology and blood chemistry normal. Liver function tests: Thymol turbidity negative; cephalin flocculation negative; B.S.P. normal; serum proteins normal; prothrombin time normal; alkaline phosphatase 12.2 units (normal 1.5 to 4.0), 14.6 (4–11–55), and 6.6 (4–21–55). Serum bilirubin (4–6–55) one minute, 3.5 mg. per 100 cc.; thirty minutes, 6.4 mg. per 100 cc. Serum bilirubin (4–8–55) about the same. Serum bilirubin (4–21–55) one minute, 1.15 mg. per 100 cc.; thirty minutes, 1.55 mg. per 100 cc. Serum bilirubin (4–28–55 at home) normal. Cholesterol (4–6–55) 331 mg. (normal 150 to 250). Cholesterol (4–12–55) 249.

Laboratory findings were definitely indicative of an obstructive jaundice, with no evidence of any parenchymal liver damage. It was then felt that this was probably an obstructive jaundice due to Thorazine. However, in view of the short course of the Thorazine and the deepening of the jaundice, it was thought advisable to have a surgical consultation as well as x-ray studies. All x-ray studies were negative, e.g.: gastro-intestinal series, flat plate of the abdomen, barium enema, and x-ray of the chest. The surgeon and attending physician were not too certain that the condition was not a surgical jaundice. However, it was decided to follow a conservative regimen of bedrest, high caloric diet, multivitamins, and some sedation. For the first ten days, there was absolutely no clinical improvement and both patient's and family's anxiety and apprehension were mounting steadily. However, about April 18, 1955, the jaundice began to subside and lessened steadily from that point on. Laboratory findings substantiated this and the patient was discharged April 22, 1955. There is still the problem of anxiety and tension which has been worsened by this period of hospitalization.

Diagnosis: Obstructive jaundice due to Thorazine.

It might be stated, by and large, with jaundice developing in a patient receiving Thorazine, little is gained by hospitalizing the patient immediately except satisfying the physician's desire for correct diagnosis. However, jaundice is a symptom which has always in my experience aroused considerable concern both on the part of the patient and his family. The physican will be pressed for a definitive diagnosis and also the prognostic implications for the future. Most of us, I feel, no matter how obvious the diagnosis may appear at times will not care to make a commitment without a reasonably good work-up of his patient. This invariably means hospitalization.

The differential diagnosis of jaundice, no matter how seemingly apparent, is rarely simple and clearcut. This is illustrated by comparing the two cases presented above. Both cases presented prodromal symptoms suggestive of an infectious hepatitis. However, the first patient had received a higher dosage of Thorazine over a three week period, while the second patient received a considerably smaller dose for only three days. Consequently, the admitting diagnosis of the first patient was jaundice due to Thorazine with infectious hepatitis to be ruled out, and vice versa for the second patient. Subsequent studies indicated just the opposite, namely, the patient thought to have a toxic jaundice had infectious

hepatitis, and the patient thought to have infectious hepatitis had toxic jaundice due to Thorazine. An interesting paradox substantiating the long accepted fact that no matter how obvious, the diagnosis of jaundice is obtained only after careful study.

In reviewing the problems presented by these cases, it may be said that there was no particular difficulty in the case of infectious hepatitis. Laboratory studies indicated parenchymal damage, mild in nature, with a fairly rapid clinical improvement substantiated by laboratory studies. However, the second patient presented problems to this author as well as the surgical consultant, and much anxiety to both patient and his family. Even though Thorazine had been administered, it was felt that it would be rash to incriminate such a short course of therapy as the cause of this obstructive jaundice. Consequently, intensive studies were done to rule out a surgical obstructive jaundice. Even after the completion of these studies, there was still doubt as to diagnosis. A conservative course was followed, which of course was proven to be the correct one to have followed.

We will admit that even though all indicated studies must be done to confirm the diagnosis so that the welface of the patient is assured, there is another aspect that is ignored, namely, the financial and the psychological burden placed on the patient and his family. This is indeed as serious a problem to them as the diagnosis is to the physician.

Consequently, it can be seen that the relatively innocuous obstructive jaundice produced is not as innocuous as reported. The overall residual permanent organic changes may be nil, but the immediate problems presented to physician, patient, and his family are important.

In reviewing the reported cases of jaundice produced by Thorazine, it appears throughout that the history and clinical course is similar. In all, there appears a rather sudden onset of jaundice within a variable time of initiating Thorazine, usually preceded by symptomatology of a viral like infection. The diagnosis would therefore appear to be one of infectious hepatitis. Laboratory studies then indicate jaundice of the obstructive type which subsides gradually upon cessation of the drug.

In conclusion, it is to be repeated that the role of iatrogenic disease must be seriously considered as an etiologic factor in symptoms presented by our patients, and every measure at our disposal taken to keep it at a minimum. In the case of drug induced iatrogenic disease, let us minimize it by utilizing wisely and cautiously the excellent drugs at our disposal.

Ridgely, Maryland

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Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee meets on the third Thursday of each month from 5–6 p.m. in the Small Hall of the Medical and Chirurgical Faculty Building. Selected cases are presented for discussion. All physicians are invited to attend the meetings.

Abstracts of Case Discussions:

1. S. W. White. Age: 53 years. Married. Patient has had repeated urinary tract infections for many years. Left kidney removed twenty years ago—diagnosis at this time said to be tuberculosis. Right ureteral stricture fourteen years ago. Kidney stone removed, 1944. Repeated urinary tract infections. During this time patient was followed by L.M.D. and seen at intervals by doctor A. Repeated cystoscopic examinations and medication. In 1954, patient was asymptomatic and urine was negative. February 1955, urine clear. Following this the patient missed several appointments and did not consult a physician until an acute episode of frequency, urgency and dysuria in August 1955. She consulted doctor B—was treated for one week with medication and then referred to doctor A. She was hospitalized August 21st—cystoscopy on August 23rd revealed a bladder lesion which was biopsied.

Diagnosis: Transitional cell carcinoma of the bladder.

Treatment: Partial resection of the bladder.

Chairman: Does anyone have anything further to say about this case?

Visiting surgeon: Yes, this happens to be my case. I have seen this patient off and on since 1941 and have brought a few notes from my voluminous office records. In 1937 she had an operation at the Easton hospital for removal of what was apparently a tuberculous kidney. One year later, in 1938, she had a pelvic laparotomy, with a suspension, appendectomy and partial removal of one ovary. In 1941, she was referred to me in regard to her right kidney. She had marked hydronephrosis and a stricture. The right ureter was dilated repeatedly without doing much good. Finally after six months of treatment with no improvement, I went in through a modified McBurney and did a resection of the ureter with end to end anastomosis. There was marked regression of the hydronephrosis, but I never felt that the urine was really clear. In 1944, she had an acute febrile situation and there was a large stone in the right kidney which was removed. I continued to see her off and on for recurrent urinary infections and she was followed in the interims by her local physician. She had repeated cystoscopic examinations. I was never satisfied that the urine was entirely clear. In 1948, she had a panhysterectomy and left salpingo-oophorectomy because of fibroids. Following this she seemed to do fairly well for a while. In 1953, I saw her with complaint of lower, left quadrant pain. Pyleogram at this time was normal. In November 1954, her urine was clear and cystoscopic examination was negative. I saw her again in February of 1955 when examination was negative and the urine was clear. I have wondered since if the lesion was not present at that time and I missed it. However, I did not see anything suspicious at the time. I did not see the patient again until August, 1955, when she was having an acute episode of frequency, dysuria, etc. I hospitalized her immediately. Cystoscopic examination revealed a lesion above the left ureteral orifice which was biopsied and showed carcinoma. At operation the malignant process was more extensive than I thought and had infiltrated considerably and extended beyond the bladder wall. I took out about half the bladder.

Committee member: Could you feel this extension on pelvic examination?

Visiting surgeon: No. She was a large, fat woman and this could not be made out on pelvic examination.

Chairman: Has she had any further treatment?

Visiting surgeon: Yes, she has had deep x-ray.

Chairman: The interesting thing to me about this case is the long history of urinary tract infection and then carcinoma of the bladder. I cannot help thinking that there must be some connection.

Committee member: As you know, we are reviewing a series of cases of carcinoma of the bladder. Many of the cases that we have gone over have shown this same history of a long period of recurrent urinary infections. Many had a history of interstitial cystitis. There are some in which the tumor must have been

* Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

missed for several months in spite of water cystoscopy.

Visiting surgeon: Don't you think that many times a doctor has his mind on cystitis, and does not look as thoroughly as he should?

Committee member: Yes, but I am beginning to think that we ought to do something—change our routine—maybe do a suprapubic cystotomy and take a good look inside the bladder in some cases. Certainly in many cases the diagnosis is not made as soon as it should be.

Visiting surgeon: In this particular case, having seen the size of the tumor, I feel that it must have been there when I cystoscoped her in February and possibly in November.

Chairman: It is quite possible, but I do not think we can call this delay. If the patient had returned as requested, the lesion might have been detected earlier. However, she was apparently not having many symptoms at that time so we cannot put much blame on the patient. There seems to have been no real delay.

2. E. W. Colored. Age: 36 years. Married. Gravida 6–1–1–4. Menstrual periods normal through March 1955. Missed period in April. In May, consulted doctor A and was told that she was pregnant. A few days later, a normal menstrual period. A normal period in June followed by intermittent pinkish spotting. She consulted doctor A—was examined and told that she had a cervical polyp which should be removed but this was not urgent. For financial reasons the patient did not have this done. In July, a normal period followed by intermittent spotting. On August 17th, an episode of profuse bleeding with clots. Patient consulted doctor B—not examined—treated with an injection and some oral medication and told that the bleeding was caused by "hormone imbalance." A similar episode of profuse bleeding one week later. Patient was again treated with oral medication and an injection. She consulted doctor B several times—given injections—pelvic examination not made until she requested examination on September 17th. She was then advised that she had a tumor and referred to the hospital and seen there on September 19th. Admitted to the hospital on September 27th. Biopsy of the cervix revealed carcinoma. Patient was referred to the second hospital for treatment and seen there on October 17th.

Diagnosis: Carcinoma of the cervix, international classification, stage I.

Treatment: Radium and deep x-ray therapy.

Chairman: Is there further information on this case?

Committee member: It is an interesting thing that this was a polypoid lesion. I have a drawing of it as it appeared the first time the patient was seen in the clinic. Probably the polyp as noted by doctor A was carcinomatous and had it been removed the lesion on the cervix would have been found.

Chairman: Even though the lesion looked like a polyp it should have been removed and biopsied because carcinoma of the cervix sometimes starts in this way. The patient says she did not have this done for financial reasons.

Committee member: I am wondering as to the financial reason. Did the doctor plan to send the patient into the hospital?

Chairman: I believe according to our record that the doctor said this could be done as an office procedure but for a fee which the patient could not afford.

Committee member: I think we had better remind this doctor that such cases may be referred to the hospital and taken care of there.

Committee member: I suppose that technically doctor B is not guilty of delay because he examined the patient one month after he first saw her and referred her to the hospital. He is really more guilty than doctor A in his treatment.

Chairman: The treatment was certainly not good. Pelvic examination was not made until the patient herself requested examination. It is amazing how often we hear this story. In this case the doctor did make a pelvic examination one month after he was first called to see the patient. According to our rule that a lapse of time of more than one month is "delay," this is not "delay," but it was certainly an unnecessary loss of time. A pelvic examination was indicated when the patient was first seen.

3. R. B. White. Age: 50 years. Married. Gravida 5. Beginning in the summer of 1953, periods more frequent than usual. Patient under care of doctor A at this time because of hypertension—physical examination including pelvic examination made—nothing made out other than an enlarged uterus. Bleeding beginning August 24th, 1954, continued to September 15th. Patient consulted doctor A and was referred to doctor B. She was hospitalized for D. & C. and biopsy on September 28th. Pathological report: "Atypical hyperplasia, endometrium; cervix, no histo-pathology." The patient had large fibroids, cystocele and rectocele. On October 1st, a vaginal hysterectomy, and anterior and posterior repair was done. Pathological report: Infiltrating squamous cell carcinoma, cervix; multiple intramural fibroids, uterus; hemorrhagic cyst, ovary. The patient was given deep x-ray therapy postoperatively.

Chairman: This case is interesting because of the negative biopsy and the positive findings in the pathology at operation. I presume this was definitely invasive and not an intraepithelial carcinoma?

Guest surgeon: Yes, it was considered invasive, although a very early lesion. The lesion was in the endo-cervix—there was nothing grossly on the cervix.

Committee member: The pathology report of "cervix, no histo-pathology" is somewhat ambiguous. The cervix was biopsied?

Guest surgeon: Yes, biopsies were taken, and were considered entirely negative.

Committee member: Did this patient have a smear?

Guest surgeon: Yes, she did. I have been doing smears routinely on all patients. When the biopsy was negative in this case, there seemed to be no reason to wait several weeks to get a report on the smear and I went ahead with the surgery.

Chairman: We have had a great problem in the length of time it has taken to get a report on a smear. I am sure you know that now if marked "rush," you can get a report within a few days.

Guest surgeon: Yes, I do know that. Now I am marking "rush" all cases on whom surgery is contemplated. In this case there really did not seem to be any reason to rush because there was nothing grossly on the cervix.

Committee member: What was the smear report?

Guest surgeon: Class V. Had I had this report I would, of course, have done a re-biopsy or conization to establish the diagnosis before going ahead with any treatment.

Chairman: I do not feel that there is any delay in this case or any reason for criticism. It emphasizes the value of cytology as an aid to diagnosis in early cases. Occasionally you will get a false negative. Dr. Brack, you have been doing some work on this, what are the figures in false negatives in biopsies and smears?

Dr. Brack: I do not remember the exact figures. As I recall in our series that included about 4500 cases, the false positive smears were about 1.4%, and the false negatives 0.6%

(There was further discussion of false negatives and false positives in smears and biopsies.)

4. D. T. White. Age: 31 years. Married. Gravida 8. Patient followed in obstetrical clinic during pregnancy. Repeated Papanicolaou smears reported as class III. Because of the suspicious smears a cervical biopsy was done at the time the patient returned for her six-weeks post-partum check. This revealed carcinoma-in-situ. The patient was admitted to the hospital for D. & C. and conization. There was no history of irregular bleeding—no other symptoms.

Diagnosis: Carcinoma-in-situ, cervix.

Treatment: Panhysterectomy and bilateral salpingo-oophorectomy.

Chairman: This is the kind of case we like to read. An asymptomatic early lesion was detected and treated. We do seem to be getting more of these cases, but there are still many discouraging ones.

Committee member: Were the smears all class III?

Visiting surgeon: Yes, they were all III's. I would like to add to the information given on the abstract that this patient was biopsied during pregnancy and our pathologist, who is a rather conservative man, would not call this carcinoma-in-situ. He read the slide as showing marked basal cell hyperactivity. It was on the basis of this that the patient was biopsied six-weeks post-partum. This biopsy was read as carcinoma-in-situ.

Chairman: This case certainly should be classified as an asymptomatic detected case.

Statistics

Cases to February 1, 1956	1145
Classification:	
No delay	376
Patient delay	493
Physician delay	94
Physician and patient delay	71
Institutional delay	31
Patient and institutional delay	22
Physician and institutional delay	4
Physician, institution and patient delay	2
Inadequate or improper treatment	11
Delay due to laboratory error	2
Asymptomatic detected cases	30
Unclassified to date	9

Scientific Papers

USE OF INTRAMUSCULAR TRYPSIN IN GENERAL PRACTICE*

LOUIS F. KLIMES, M.D.

A review of the medical literature reveals a paucity of data relating to the parenteral use of crystalline trypsin as a therapeutic agent. A preliminary report by Innerfield et al.[1] gave evidence that intravenous doses of crystalline trypsin, if given slowly, were safe and effective in cases of thrombophlebitis and ischemic leg ulcers.

These observations were confirmed by Laufman and Roach,[2] who used intravenous doses of about 100 mg. of trypsin by intravenous infusion. They found that the inflammatory symptoms abated in one-half the time or less in trypsin-treated patients as compared to anticoagulant-treated patients, but the thrombosed veins remained palpable for as long during trypsin therapy as that during anticoagulant treatment.

Further confirmatory data were reported by Fisher and Wilensky.[3] They obtained good results in relief of symptoms of acute thrombophlebitis, no effect in arterial conditions, and equivocal results in chronic thrombophlebitis on doses of four to twenty milligrams of trypsin by intravenous infusion. These investigators used a preparation of crystalline trypsin (5 mg.) in sesame oil (1 ml.) by the intramuscular route in eighty cases of acute thrombophlebitis and obtained satisfactory results in seventy-five of these cases. They gave one-half milliliter doses or 2.5 mg. of trypsin once or twice daily.

Marked reduction of acute inflammatory reaction in thrombophlebitis by the use of 80 mg. of trypsin intravenously was reported by Peck.[4] He observed no effect on the basic anatomical defect. Such side effects as flush, short-term elevation of temperature, pain at site of infusion, and thrombus formation were observed.

Confirmatory reports of excellent clinical results obtained with intramuscular trypsin were issued by Innerfield.[5, 6] He recommended continued trypsin treatment in chronic recurrent thrombophlebitis for therapeutic effect.[5] He found the trypsin in sesame oil to be very effective in acute thrombophlebitis, diabetic cellulitis and leg ulcer.[6]

The clinical application of trypsin in sesame oil is not limited to the management of thrombophlebitis. Hopen[7, 8] and Hopen and Campagna[9] reported good to spectacular results in acute inflammatory and thrombotic ocular disturbances. Golden[10] used the preparation in eighty-three patients with acute inflammatory disorders including bronchitis, bronchial asthma, abscesses, thrombophlebitis, and traumatic and suppurative inflammation. He reported improvement by the third day in eighty-one of the eighty-three patients studied. Boines[11] reported the use of trypsin in sesame oil in a series of acute poliomyelitis cases with very gratifying results. Goodson[12] obtained negative results with two to ten mg. of trypsin by the intravenous route in rheumatoid arthritis patients.

The clinical data establish a definite use for trypsin in oil. Inflammation, edema and pain are without doubt favorably influenced and clinical improvement can be obtained in a much shorter period of time than heretofore possible with conventional measures.

A physician in general practice is confronted

* Submitted October 11, 1955 for publication in the MARYLAND STATE MEDICAL JOURNAL.

TRANS WORLD AIRLINES
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January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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with many clinical problems which test his abilities and ingenuity, and tax the patients' serenity. A therapeutic measure which would control at one and the same time such related entities as inflammation, edema, and pain is something the average physician has been seeking for a long time. Probably trypsin in oil is the answer to the many physicians' prayers.

Materials and Procedure

Eleven patients were selected for Parenzyme (crystalline trypsin in sesame oil) therapy. The sex, age, distribution and the diagnoses are listed in table I.

The Parenzyme was injected deep intramuscularly in doses of 0.5 ml. to 1.0 ml. at daily intervals in the buttocks. In the case of patient M.T., there were rest periods of one or two days between several series of injections.

Treatment was individualized for each patient, depending on the diagnosis and the severity of the existing disease entity. Judgment of the results by the patients influenced the decision to either continue or interrupt the Parenzyme injections. Each patient was advised that no guarantees were attached to this therapeutic procedure; however, it was suggested that Parenzyme did offer some possibilities.

Discussion

An understanding of inflammation, edema, and pain should not be amiss at this point.

Pain represents a danger signal to the individual indicating something is wrong. Although biological and physiological adjustments are not necessarily dependent on it, this phenomenon should be given rapid and serious consideration. Pain represents that agency in the body which reveals the presence of disease.

What is the relationship of inflammation to pain? It is not difficult to believe that tolerance to pain is appreciably lowered by inflammation; that is, a lowering effect on pain threshold is exerted by inflammation.

Celsus pointed out that every type of inflammation is characterized by four cardinal features, namely, redness (Rubor), swelling (Tumor), heat (Calor), and pain (Dolor).[13] To these John Hunter added another feature, "loss of function."[13] Finally, Menkin[14] completed the picture with the addition of a biochemical feature. In inflamed areas there exists a state of proteolysis or breakdown of protein. This phenomenon is markedly enhanced in diabetes, and is manifested by the increased insulin requirements. Thus, in a diabetic patient with inflammation, the disease is frequently accentuated.

Edema is defined as a swelling due to effusion of watery liquid into the connective tissue. Inflammatory edema is attended with redness and pain.

The treatment should then be directed to the facilitation of drainage from the inflamed area, which will remove noxious materials to reduce inflammation and thus relieve or alleviate pain.

How does trypsin accomplish this? According to Martin,[15] "Trypsin administered either intramuscularly or intravenously acts by its transfer to the inflammatory site. The concept of plasmin activation at the site of injection no longer seems feasible, since no detectable differences in blood plasmin concentration have been found. At the site of the inflammation, the trypsin functions as a depolymerase. It may also cause some plasmin activation." This investigator believes that "the key to the action of trypsin in an inflammatory reaction relates directly to the restoration of biological continuity, to the restoration of circulation, and thereby, prevention of further cellular damage and death."

Beiler et al.[16] demonstrated the effect of trypsin on experimentally produced edema and concluded that different types of edema are not necessarily equivalent quantitatively in their response to trypsin. The dosages and dose schedules which have been found to inhibit one type of edema will not necessarily prove effective against another. . . . This obviously ap-

plies with at least equal force to clinical edemas as opposed to those produced in the laboratory. After a study of the anti-inflammatory action of trypsin, Martin et al.[17] concluded that "It would thus appear that the anti-inflammatory action of trypsin is a result of direct facilitation of drainage from the inflamed area. The abilities of trypsin to increase permeability, cause vasodilatation, and reduce viscosity of edema will all have the effect of facilitating drainage."

Common to all types of thrombophlebitis is pathologic evidence of thrombosis and inflammatory reactions in the various coats of the venous wall. There are at least three factors responsible for thrombophlebitis:

1. A local traumatic, infectious, toxic, or preexisting lesion of the intima of the vein. Any of these factors can initiate an inflammatory state.
2. Relative stasis of venous flow. This may be a sludging of the blood phenomenon resulting from any of the above factors.
3. Changes in the composition of the blood itself. This probably relates to Menkin's[14] biochemical feature.

In acute thrombophlebitis, there is an acute obstruction of the lumen and inflammation of the wall of the vein. Pain and tenderness vary with the severity of the inflammation and the degree of congestion of the distal parts of the limb. Swelling of the limb is produced by intense congestion plus varying degrees of edema.[18] Homans[19] suggested that although the venous obstruction is probably the chief basis for the edema in some if not all cases, obstruction to the peri-venous lymph vessels in the region of the femoral ring is an added factor which must be considered.

Thus, an understanding of the conditions being treated, and an insight into some of the possible mechanisms involved in trypsin therapy, made it easier to interpret the clinical observations. Judgment of this treatment was based on the patient's objective and subjective responses.

TABLE I

Patient	Sex	Age	Diagnosis	Number Injections	Results
M.T.	F	72	Diabetic ulcer left leg	63 I.M.	E
H.E.	F	59	Diabetic ulcers toes	30 I.M.	F
W.E.	M	76	Thrombophlebitic leg ulcer	15 I.M.	F
M.V.	F	78	Thrombophlebitic leg ulcer	6 I.M.	E
D.H.	F	38	Acute subdeltoid bursitis	4 I.M.	E
V.K.	F	45	Acute subdeltoid bursitis	8 I.M.	F
G.B.	F	52	Acute subdeltoid bursitis	8 I.M.	F
J.M.*	M	49	Chronic bursitis, multiple sclerosis	7 I.M.	E P
A.K.	F	50	Severe thrombophlebitis	10 I.M.	E
E.H.	F	70	Rheumatoid arthritis	4 I.M.	F
A.C.	F	56	Thromboangiitis obliterans	4 I.M.	P

* Patient J.M.: Obtained excellent result for bursitis—no effect at all on the multiple sclerosis—result P.
E—excellent; F—fair; P—poor.

Results

The clinical results are tabulated in Table I. Of the eleven patients, five had excellent results, five had fair results, and one patient a poor result. Inflammation was rapidly brought under control, and more significant was the relief of pain in these patients. The failure was a case of Buerger's disease, but a question arises, "What would a larger number of injections have done for this patient?"

With the improvement in the ulcers in the diabetic patients there was a significant drop in the insulin requirements. In the case of M.T., requirements dropped from 80 units daily to 20 units.

Several of the patients reported pain at the site of injection, but this reaction was not severe enough to cause interruption of the injections.

Comment

The results obtained in the small series of cases are significant because they represented real medical problems. They had been subjected to

many other types of treatment without apparent improvement. Parenzyme† (trypsin in sesame oil) proved effective and deserves admission to the physician's armamentarium as an adjunct in the treatment of those entities complicated by inflammation, edema, and pain. In a majority of cases these factors can be rapidly controlled with Parenzyme, and the patient can progress to complete recovery.

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† Parenzyme: The National Drug Company, Philadelphia, Pa.

ACETIC ACID GEL FOR THE TREATMENT OF INDOLENT SKIN INFECTIONS*

IRVING L. OCHS, M.D.

Infected ulcerations in the skin are often difficult to cure in spite of many therapeutic agents available. These lesions are often resistant as a result of underlying vascular, or other physiological insufficiency; however, there are indolent wounds with excellent circulation that resist healing, because the organisms responsible are fast to the available antibacterial chemicals that can be applied. Usually the problem is a combination of both of these factors.

The use of acetic acid wet dressings is one of the methods used to treat such indolent surface

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infection, or infections in accessible locations. The method has been successfully applied for many years in cases where pyocyaneus, or other gram negative bacillus, are the offending organisms. Acetic acid was shown by several authors[1, 2] to be bacteriacidal against, not only gram negative organisms, but also gram positive organisms, in concentrations that do not irritate tissue. We have been able to demonstrate the antibacterial effect of acetic acid in dilute concentration against C. tetani, perfringens, and other anaerobes.

Acetic acid is a normal component of body fluids, and takes part in several metabolic processes, and consequently is not toxic or allergenic in these dilutions. It is innocuous to the body, and split skin grafts have been grown in acetic acid solutions, whose concentrations were much higher than necessary to stop the growth of most common pathogens.[3] Otologists successfully use dilute acetic acid in the treatment of chronic external and middle ear infections.[4]

Acetic acid wet dressings have undesirable features which limit their use. The most important deterrent is that they require the patient to be immobilized and unclothed. Furthermore, the solution requires replenishment at frequent intervals, necessitating frequent nursing care. The gauze pack acts as a wick, favoring the evaporation of water from wound exudates and the medication. This results in a concentration of electrolytes, which may become irritating by the hypertonicity of the solution. The gauze is somewhat abrasive and, in addition, may cause trauma when removed from the adhering granulations of the wound.

In an effort to obviate these physical disadvantages of gauze, and also to provide specific advantages, a gel containing acetic acid was formulated. Hydrous gels are largely all water, and the mass is gelled or immobilized by a delicate network of fibrils. The hydrous structure permits a slow and continuous diffusion of the aqueous phase to the surface where the acetic acid is then available for therapeutic action. Because of the slowness of diffusion, the concentration of acetic acid in the gel may be substantial, thus providing a reservoir effect. The gels are also capable of absorbing a considerable amount of exudate from the wound before becoming fluid. This characteristic of the gel dressing reduces the necessity for frequent nursing care.

An 0.5% acetic acid solution is usually used in wet dressings. A 2.0% acetic acid solution, contained in a carboxy-methyl-cellulose gel, is used in this work. The gel is made up into a pad approximately one third of an inch thick, and "sandwiched" between sheets of wax paper and cellophane. In use, a section slightly larger than the ulcer is cut and the wax paper removed before applying the gel pad to the wound. The cellophane sheet cuts down liquid loss by evaporation. This preparation, in addition to other qualities, has the advantage of transparency, so that the healing progress can be observed without removing the medication. The gel pad is bandaged into place permitting the patient to be ambulant. Wounds that are particularly exudative require additional dressings which can be applied by the patient at home. The dressing is self sterilizing.

The patients discussed were treated in the Johns Hopkins Hospital surgical clinic over a period of approximately eighteen months. Most had chronic leg ulcers and usually these patients had some vascular insufficiency either venous, arterial, or both.

About one half of the successful cases previously had the benefit of prolonged treatment without obtaining healing.

A. P., a twenty-two year old white male, had a trophic ulcer on his leg of undetermined etiology measuring 5 x 9 cm. This wound was of five years duration, resisting the usual therapeutic routines. Proteus vulgaris culture was grown from the profuse foul exudate. Upon application of the gel, immediate cessation of the discharge occurred, and the wound healed completely in three months. Figures 1 and 2.

N. P. J., a fifty year old negress, had a 10 x 12 cm.

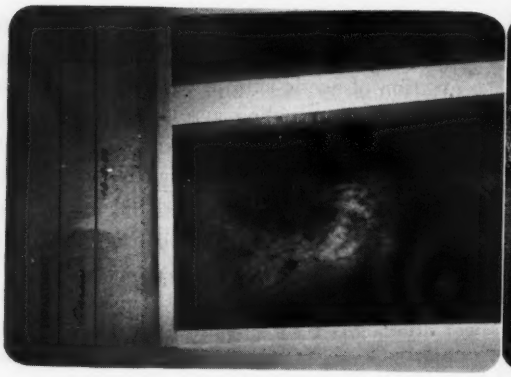

FIG. 1

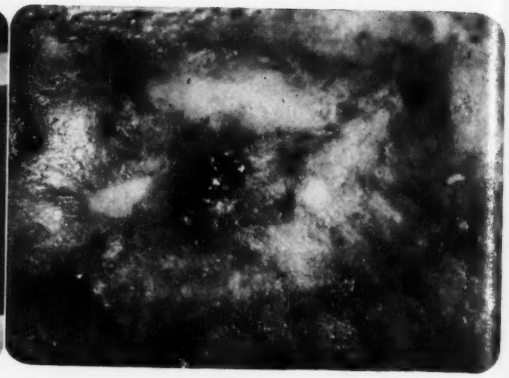

FIG. 2

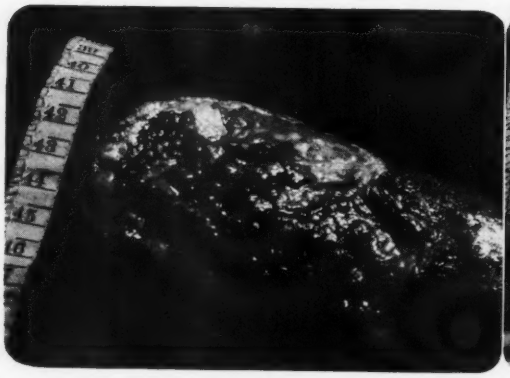

FIG. 3

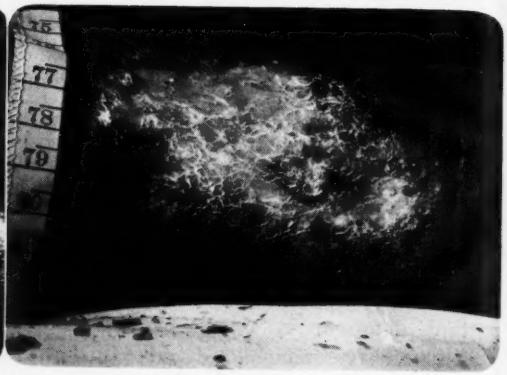

FIG. 4

FIG. 5

FIG. 6

ulcer on her left leg for seven years. She had been treated during this interval with various measures, including topical applications, systemic antibotics, surgical excision, and skin grafting. A prolonged period of bed rest in the hospital during which time the patient was successfully treated for carcinoma of the esophagus by surgical excision, did not effect healing of her leg lesion. Treatment with the gel resulted in prompt elimination of odor and discharge. The patient was completely healed in three months. During the course of treatment the healing was accelerated by the application of a pinch graft. This graft took, and grew on the ambulant patient, while maintained in position by an acetic acid gel pad. Figures 3 and 4.

G. S., fifty year old old white female with diabetes, developed a proteus infection in the wound of a radical mastectomy. She was treated for eight weeks with the usual local measures, plus systemic penicillin, streptomycin, and terramycin. At the time of discharge from the hospital, she had a wound 3 x 13 cm. with multiple viable, but not proliferating, pinch grafts. There was a profuse foul exudate which was discouraging to the patient, and difficult to control. Two days following the application of the acetic acid gel, the odor and discharge stopped. The pinch grafts proceeded to proliferate epithelium. The wound healed completely in one month. Figures 5 and 6.

In this series, 36 patients were treated with varying degrees of success. A significant number did not completely epithelialize, and in these cases grafting was used on the clean wounds.

Healing occurred to some degree in all patients. One of the most obvious benefits of this technique is the satisfaction the patient received from the prompt elimination of odor and exudate. The help and cooperation of the Vascular Clinic Staff is greatefully acknowledged. Dr. Erida Reichert assisted in the bacteriological studies associated with this work.

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CARCINOMA OF THE CERVIX*

RICHARD W. TeLINDE, M.D. and GERALD A. GALVIN, M.D.

The purpose of this article is to discuss the symptomatology and methods of diagnosis of cervical cancer and to acquaint the practitioners of the State of Maryland as to how and when the diagnostic procedures necessary to the detection of this disease may be completed. Next to cancer of the breast, cervical cancer is the most common malignant neoplasm occurring in women. This fact alone gives great importance to this subject but the fact that the disease is curable in its early stages makes it doubly important that practitioners be informed as to its early detection. Since the cervix is essentially an organ of the external surface of the body it may be palpated; it may be inspected; and it may be smeared and biopsied. Thus, we have a great advantage in the detection of this disease as compared with the detection of cancer of many internal organs, such as the ovary and the intestinal tract.

Progress in curing malignancy in general is slow, but in reviewing the past several years it is

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One of a series of papers from the Maryland Division of the American Cancer Society that will appear from time to time.

obvious that material advances have been made in the treatment of cervical cancer. In order that practitioners may be encouraged in the early detection of this disease the following facts are presented:

Fifteen years ago the average five year "cure" rate of cervical cancer in the better clinics was about twenty-five per cent. Our results for five year cures for the five year period ending December 31, 1953 showed an overall salvage of fifty-three per cent. Thus in a decade and a half the curability rate has been more than doubled. This improvement has been chiefly due to three factors:

(1) The inclusion in the material of many more early cases.
(2) Improvement in irradiation techniques.
(3) An improvement in our knowledge concerning the selection of certain cases for surgery.

There is but one important symptom of cervical cancer and that is an irregular show of blood from the vagina. It is true that early cervical cancer and, at times, even an advanced cervical growth, may be present without any bleeding. Nevertheless, in the vast majority of cases, bleeding occurs when the disease is still curable and hence it is a symptom which should be given serious consideration. Cervical cancer is not necessarily a disease of old age. The average age of occurrence is forty-seven or forty-eight years but many women in the thirties and a few in the twenties succumb to it. This is one of the great tragedies about the disease for it often takes a mother when she still has small children who have great need for her. Thus, a young woman with intermenstrual bleeding is a subject for investigation as well as the older ones. Excessive bleeding at the time of the period is seldom a symptom of early cervical cancer but even a slight intermenstrual show may be indicative of a cervical neoplasm. Since the appearance of cervical cancer so frequently coincides with the time of the menopause, the occurrence of irregular bleeding in the late forties or early fifties is of great importance. The tragedy is that women are likely to disregard this bleeding, thinking that it is a manifestation of the menopause. Often they are encouraged in this belief by their friends who suffered from benign functional bleeding during their menopausal years and eventually got well spontaneously. But far worse is the incontestable fact that many women are encouraged in their erroneous belief by the family physician. Bleeding occurring a year or more after the last regular period should always be considered as postmenopausal bleeding. Much postmenopausal bleeding must be ascribed to the common use and misuse of estrogen therapy but it is never safe to make such an assumption. The only safe attitude toward postmenopausal bleeding is that it indicates malignancy until proven otherwise.

Although it is impossible to overstress the importance of irregular bleeding, may we repeat that the lesion can exist without abnormal bleeding. This constitutes one of the important reasons for routine annual pelvic examinations of all women over thirty.

In addition to irregular bleeding there are, of course, other symptoms of cervical cancer. They are: a foul water discharge often tinged with blood, loss of weight, anemia, pelvic pain often radiating into the lower extremities. However, these are usually the signs of advanced cervical cancer which has spread beyond the cervix and all too often indicate impending death. Thus the detection of these text-book symptoms are often of little value from the point of view of saving the patient's life.

It is probably well known to most of the practitioners of the state that there has been in existence a Committee on Pelvic Cancer of the Medical and Chirurgical Faculty for the past three years. This Committee has for its purpose the education of the doctors in the early recognition and proper treatment of this disease. Most of the hospitals of Baltimore participate and the residents of these hospitals notify the Committee's representative whenever a case of

cervical cancer is admitted. The representative, who is a tactful, medically trained woman, interviews the patient to find out whom she has consulted and what diagnostic procedures have been carried out. To date, we have had no trouble with patients becoming suspicious from this interview. In fact many women have remarked that they enjoyed the visit and have asked our representative to return. The Committee meets once a month and discusses selected cases. All doctors who have been connected with the cases are invited to the meeting and a frank discussion of the cases is carried out completely anonymously as far as the patient and physicians are concerned. At the conclusion of the discussion, the case is classified as to whether there has been a delay in getting proper treatment. A lapse of over a month is considered delay. There are four classifications: No delay; patient delay; physician delay and institutional delay.

Any physician present may disclose himself and throw light on the case but he may remain anonymous if he desires. If the physician who has been concerned with the case is not present a summary of the discussion is sent to him. If he is present and has failed to make the proper diagnostic studies in the presence of symptoms, he is apt to leave the meeting with a feeling that he has sinned and, we hope, with a determination to sin no more. Much of the work of the Committee has been discouraging. Over and over again with disheartening monotony we find that a physician has not even made a bimanual examination in the presence of bleeding. Often he tells the patient to return when the bleeding stops as he cannot examine her in the presence of bleeding. Perhaps the bleeding continues and hence the patient does not return until the carcinoma is incurable or she consults another physician when she becomes suspicious that the continued bleeding indicates something serious. One of the repeated stories given our representative is that of receiving a "shot" of estrogen without any examination. But there is a brighter side to the picture. In the first year of the Committee's activity we saw only advanced cases of cancer but in the last year we have seen an increasing number of very early cases, many of which were detected in women without symptoms who went to their doctors for routine examinations.

The importance of early diagnosis is well illustrated by reviewing the recent report of the five year "cure" rate of the pelvic cancer clinic at the Johns Hopkins Hospital.

Stage 0 (preinvasive cancer)	100%
Stage 1 (gross lesion limited to cervix)	85%
Stage 2	42%
Stage 3	21%
Stage 4	0

What constitutes a proper examination for the woman who presents herself with or without symptoms suggesting cervical cancer:

A speculum examination with good visualization of the cervix should first be done. This should be done before the bimanual examination because the glove lubricant interferes with the reading of the cytological smear. The smear is first made using the wooden spatula of Ayre as illustrated (Figure 1). The spatula is rotated about the external os region scraping the loose lying upper cell layer from the cervix. A second smear is made from the posterior vaginal fornix using the other end of the spatula. The material thus obtained is spread upon a glass slide and the slide dropped into the fixative before it dries. Containers fitted with slides, fixative and spatulas can be obtained upon request from the State Board of Health. Upon returning the container to the State Health Department, the slides will be examined and a report sent to you free of charge. The cytologists at the Health Department are very reliable, and we are training others to relieve the present ones of their great overload. The error in the reports of our cytologists is less than one per cent.

Like all laboratory tests, the doctor must know how to interpret the reports on cytological examinations. A Class I report is normal. A

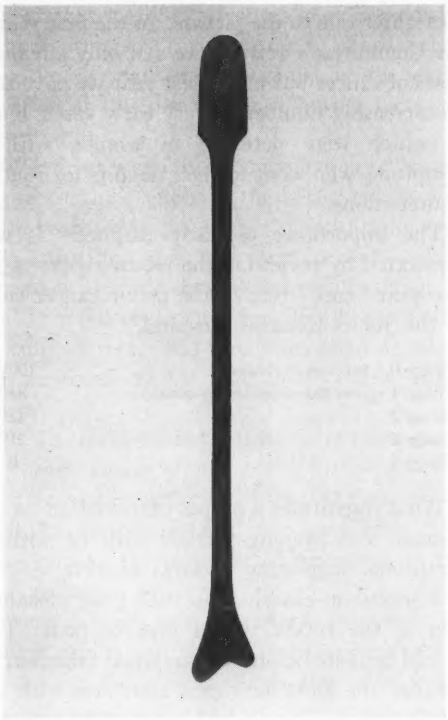


FIG. 1

Class II report indicates atypical benign cells but may be regarded as negative for cancer. A smear reported as Class III must be regarded as suspicious and calls for another smear and a cervical biopsy. A smear reported as Class IV is definitely positive for cancer as is Class V. Nevertheless, definitive treatment should never be instituted on the evidence of a positive smear alone. In the first place, there is the rare chance that the report may be a false positive. The diagnosis should always be confirmed by biopsy before starting treatment. The exact nature of the cervical malignancy and its stage of development must also be ascertained and, indeed, if no malignancy is located on biopsying the cervix, endometrial cancer must be sought for by curettage. The methods of treatment of cervical cancer and corpus cancer are quite different and it is essential to make the differentiation before starting treatment. Likewise, the treatment of cervical cancer differs with the stage of the disease and the exact stage must be known before treatment is instituted.

Continuing with the speculum examination, after taking the smear the mucosa of the cervix is carefully inspected and biopsied if indicated.

What are the indications for biopsying the cervix?

a. The cervix of any woman in whom there is a history of intermenstrual or postmenopausal bleeding should be biopsied as well as smeared, regardless of the normal appearance of such a cervix.

b. Every cervix should be biopsied on which there is a suspicious area. This may be a small friable area, an area of leukoplakia, an area of deeper red color than the surrounding cervical mucosa and an area which feels suspiciously irregular or hard. These suspicious areas should be biopsied regardless of a report of a negative smear.

c. Every cervix should be biopsied from which a suspicious or positive smear has been obtained, regardless of the normal appearance of the cervix.

d. A biopsy should be taken of every gross obvious cervical cancer. Very rarely there occurs a lesion such as tuberculosis or lymphopathia which simulates cancer. Regardless of the "typical" appearance of a gross cervical lesion one can only count in his statistics of morbidity cases in which the lesion has been proven microscopically.

How should the cervix be biopsied? There are many biopsy instruments on the market but we prefer the Gaylord forceps shown in Figure 2. Often in elderly women, especially, it is advantageous to steady the cervix with a two-prong tenaculum. A perfectly satisfactory biopsy can be taken with a small scalpel if a special instrument is not at hand. In spite of the fact that all gynecologists recommend cervical biopsy there is much confusion about the best way to obtain the specimen. First, it must be emphasized that a single biopsy taken in a

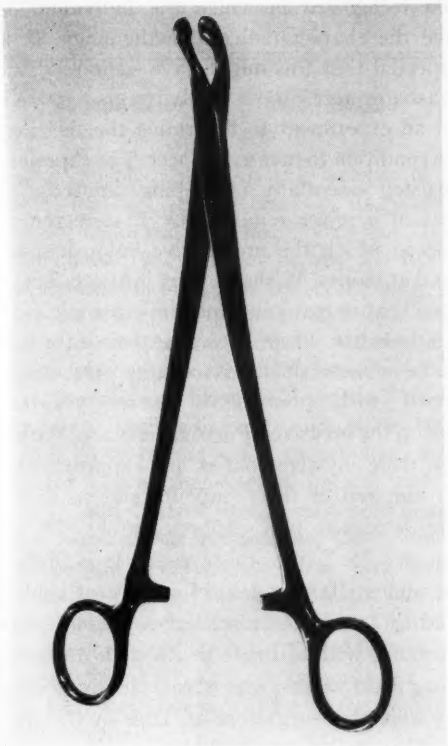


FIG. 2

haphazard way for one of the above indications has a greater chance of missing the cancer than finding it in the early stage of the disease. Each one of the above mentioned "suspicious" areas should be biopsied, but this is not sufficient. The cervix should be biopsied "around the clock." This may mean four specimens at 12, 3, 6 and 9 o'clock but when the cervix is large six or even eight specimens had best be removed. Since we have found that most cervical cancers begin at the squamo-columnar epithelial junction, this is the area to be biopsied. This is usually at the external os but it may vary. It can usually be recognized by a sudden change in color of the mucosa from dark red to pink. Sometimes this transition is up in the cervical canal and if possible it is well to insert the punch forceps into the canal for a specimen. When this is not possible the cervical canal can be scraped with a very small curette and the material thus obtained spread on a slide and fixed exactly as for a smear. After having taken the biopsies they should be dropped into a fixative and sent to the pathological laboratory at the University of Maryland or to the Gynecological Pathology Laboratory at the Johns Hopkins Hospital. An expert diagnostic opinion will be sent to the doctor without cost to him or the patient.

After the speculum examination a bimanual examination should be made and the character and extent of the growth noted. Note should be made as to palpable extension of the growth into the vagina, broad ligament and other organs. The involvement of the broad ligaments can usually best be evaluated by rectal examination. However, the exact evaluation of the growth must be left to the gynecologist who is to carry out the definitive treatment.

It is not the primary purpose of this paper to consider the treatment of cervical cancer. However, it may be of interest to the practitioner to become familiar with the current views on therapy. Following the initial attempt to eradicate the disease by radical surgery at about the turn of the century, radium therapy for malignancy was discovered. The surgeons gladly relinquished the advanced cases for radium therapy and considerable palliation and a few cures were obtained. Gradually, more and more early cases were treated by irradiation until by the mid-twenties practically all cases were treated by irradiation. This continued until about a decade ago when it was thought by some surgically minded gynecologists that radical pelvic surgery should be given another trial. Accordingly, selected early cases were treated by radical abdominal hysterectomy and pelvic lymphadenectomy. Cases were carefully selected for this experiment and a great number of cases have been treated surgically with practically no mortality. The free use of blood, plasma and antibiotics undoubtedly have contributed greatly to the low mortality.

Without going into a detailed statistical

analysis it can be said that the five year salvage from this type surgery is practically identical to our salvage with irradiation therapy in Stage I of the disease. However, there is an appreciable occurrence of urinary fistulas among the surgically treated cases, a complication which practically never occurs with irradiation therapy at this stage of the disease. Therefore, after a careful analysis of the results by the two methods of treatment we have concluded that irradiation therapy will accomplish as many cures with fewer complications than radical surgery. At the Hopkins Clinic we perform the radical hysterectomy with lymphadenectomy only in the Stage I cases which appear to be resistant to irradiation therapy. Most everyone is in agreement that in the more advanced stages, irradiation therapy is preferable. Brunschwig at the Memorial Hospital in New York is an exception to this rule and has performed ultra-radical surgery on a great group of advanced cases. This ultra-radical surgery, known as the exenteration operation, has resulted in a very small salvage and in most instances for a very short period of time. It appears to us that this very small salvage when balanced against the total discomfort of the whole group during a prolonged period of postoperative suffering hardly seems to justify the surgery except, perhaps, in a few carefully selected cases which fail to respond to irradiation.

There is one more phase of this subject which should be mentioned, especially since it offers great hope for the future. For several years a microscopic picture of the surface epithelium has been recognized in which the individual cells have the characteristics of malignancy. It was suspected that this might have some relation to invasive cancer. About twelve years ago we began an experiment to determine the relation of this condition to invasive cancer. The experiment consisted essentially of making semiserial sections of cervices removed by hysterectomy in cases in which the preinvasive lesion had been found at biopsy. Without going into detail, it was found that in many instances microscopic cancer already exists. From clinical experiments it has also been ascertained that a large percentage of women with preinvasive cancer eventually develop the invasive form of the disease. We have now done hysterectomies on, approximately, two hundred of these patients and to date all have remained well. Approximately, 75 have been well for five or more years. It is probable that almost 100 per cent of such cases could be cured by irradiation also, but we have had one recurrence with ultimate death with metastases among eight women who were irradiated because they were poor surgical risks. Thus by the proper use of the smear and cervical biopsy it is possible to discover a malignant cervical lesion which can be cured by surgery in something approaching one hundred per cent.

The Johns Hopkins Hospital
Baltimore 5, Maryland
(Dr. TeLinde)
113 West Monument Street
Baltimore 1, Maryland
(Dr. Galvin)

Special Article

Joseph Albert Chatard, M.D.
1879–1956

Doctor Joseph Albert Chatard, member of the Faculty since 1904 and, successively, its Secretary (1920–27), Vice-President (1928), President (1933) and Treasurer (1935–55) died January 27, 1956 at Johns Hopkins Hospital of leukemia. He was seventy-six years of age. To explain his residence in Baltimore, for which his untold friends will always be grateful, we must go back to 1796, when one Toussaint L'Ouverture, a negro chieftain, and his followers rose in rebellion in San Domingo (later Haiti) and declared this island free of French domination. Prominent among the expelled French was Dr. Francois Pierre Chatard, who, after certain peregrinations, found himself in Baltimore, just in time to join battle with an epidemic of yellow fever. During the following century and a half, Baltimore was blessed with a succession of Doctors Chatard—Ferdinand Edme, Sr. and Jr., Joseph Albert and Ferdinand Edme IV, all in straight descent from Pierre, and Silas Marean and Ferdinand Edme III who were collateral.

J. Albert Chatard took degrees at Loyola College and the School of Medicine of Johns Hopkins University (1903) and, while interning, fell before the interne's old adversary—the bacillus of Koch. He recounted how he retired to a farm in Maine and slept the winter away; by spring, he tested his strength and found gradually that he was well. His recovery was complete. Returning, he went to work under Osler studying all the cases of pneumonia at Johns Hopkins Hospital from 1889–1905; the results were included by Osler in his Text-book of Medicine. Subsequently, he studied several months at Oxford, then began his fruitful career in Baltimore. For eighteen years he taught at Johns Hopkins Medical School, and he was elected to the staffs of Union Memorial, Women of Maryland, Mercy and Bon Secours Hospital.

In 1913, he married Alice Marie Whelan, who bore him a daughter, Octavia (wife of Dr. Hammond J. Dugan) and two sons—Dr. Ferdinand E. Chatard IV and J. Albert Chatard. This family group gave him notable support in a life that was not always easy, since for many years Dr. Chatard was one of very few physicians in general medical practice who lived in the heart of the City, and demands on him were severe and unpredictable.

On the outbreak of World War I, he promptly took a commission as Captain in the Medical Corps and left early in July 1917 to direct a small unit of Medical Officers assigned to search out and discharge

Joseph Albert Chatard, M.D.

soldiers with pulmonary tuberculosis. Armed only with stethoscopes (mass roentgen examinations were not then in use), this group examined somewhat over 20,000 recruits before their divisions departed for France. The incidence of typical physical signs of the disease was about 0.75 per cent; when reports were filed from other camps where similar examinations were held, a striking uniformity of infection was found in these boys who had passed through induction centers. In this valuable preventive operation, Captain Chatard showed executive ability; he was subsequently Chief of the Medical Service at Fort McHenry, then held a similar position at a Base Hospital in France, returning with the rank of Lieutenant-Colonel. Thereafter, in addition to a busy practice, many interests and honors came his way.

He became President of the Baltimore City Medical Society (1930), member of the State Board of Mental Hygiene, Medical Advisor to the Gilman School, Trustee of the O'Neill Hospital Fund, and, bearing no grudge against the race that had expelled his progenitor from Haiti, took quiet satisfaction in giving medical attention to the Sisters of the Oblate Order of Providence. It is difficult to express the debt the Faculty owes to one who labored so long and fruitfully in its behalf. It called on him constantly and he always went the extra mile. His devotion to Medicine and the Faculty is perhaps best expressed by himself in his Trimble Lecture of 1930 and in his informal remarks (Md. State Med. Journ., Jan. 1956) when he received a silver plate from the hands of Dr. W. M. Firor, representing some of Dr. Chatard's friends.

There was an essential modesty about the man, for he gave the impression of being vitally concerned, not with his personal fortunes, but with being a torch-bearer to the best of his ability, in historical perspective, in various matters that were of deep moment to him. Thus, he doubtless pictured himself as merely a standard-bearer in the ranks of the Roman Catholic Church, as his father's successor in the Dinner Club (Medical Reunion) to which he was so devoted, and as one Dr. Chatard in a long progression of Chatards who honored our profession. His dearest wish, as ours must be also, would be that their shadow never grow less.

JOHN T. KING, M.D.

ANNOUNCEMENT

The following short courses will be conducted at The Children's Hospital of Philadelphia in May and June 1956.

1. Pediatric Advances for Pediatricians and General Practitioners. May 28 through June 1, 1956. A Refresher Course conducted by the Staff of the Children's Hospital of Philadelphia, in collaboration with the Department of Pediatrics of the University of Pennsylvania and the Camden Municipal Hospital.
   Tuition—$100.00.
2. Practical Pediatric Hematology. June 4, 5 and 6. Conducted by Dr. Irving J. Wolman and other members of the Hematology Department of the Children's Hospital, under the auspices of the Graduate School of Medicine, University of Pennsylvania.
   Tuition—$60.00.
3. Blood Group Incompatibilities and Erythroblastosis Fetalis. June 7 and 8. Conducted by Dr. Thomas R. Boggs, Jr. of the Philadelphia Serum Exchange of the Children's Hospital of Philadelphia, under the auspices of the Graduate School of Medicine, University of Pennsylvania.
   Tuition—$50.00.

For information write to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46.

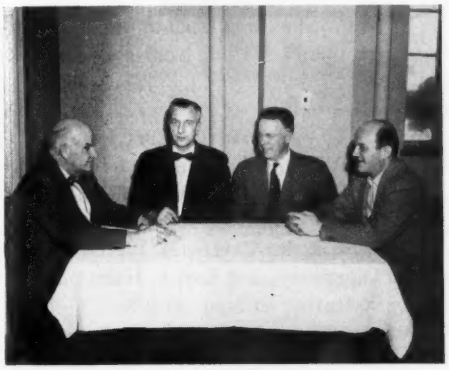
Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

OFFICERS FOR 1956

The Allegany-Garrett County Medical Society held its annual election of officers at the January meeting, with the following physicians elected to serve during the year 1956; *President*, Dr. William Alfred VanOrmer; *Vice-President*, Dr. Benedict Skitarelic; *Secretary*, Dr. Leslie E. Daugherty; *Treasurer*, Dr. Leo H. Ley, Jr., *Delegates*, Dr. James T. Johnson, Jr., and Dr. Hilda Jane Walters; *Alternates*, Dr. Frank T. Harrat and Dr. Leland B. Ransom.



DR. LESLIE E. DAUGHERTY, *Secretary*; DR. BENEDICT SKITARELIC, *Vice-President*; DR. W. ALFRED VANORMER, *President*, AND DR. LEO H. LEY, JR., *Treasurer*

Dr. Daugherty was elected to serve as Journal Representative.

I will practice my profession with conscience and dignity

ON TO BALTIMORE

May 2, 3, and 4 is or should be a blank space on our work register. The Annual Meeting of the Faculty will be in session this week and the best program yet scheduled is on order.

Not forgetting the Art Exhibit, I trust many have sent or will take some of their handicraft for exhibition. Paintings, sculpture, photographs and art in any form may be submitted. There will be no judging. You can't lose.

"Vesalius in Zanti"

There are two ways of spreading light, to be;
The candle or the mirror that reflects it,
I let my wick burn out, there yet remains
To spread an answering surface to the flame
That others kindle.

Wagner in the life of Osler

FIRST STANDARDIZED HOSPITAL IN CUMBERLAND

The Western Maryland Hospital, an outgrowth of the Protestant Home and Infirmary, became standardized in 1922 and acceptable to the American College of Surgeons.

From 1888, the Institution was called the Protestant Home and Infirmary of Cumberland and used as a home for the aged and infirm people. Built in 1889, it was chartered by an act of the Legislature, March 1888.

The Act provided for twelve directors, seven appointed by the State and the other five elected by the State Directorate and such citizenry of Allegany County as contributed fifty dollars or more annually to the support of the institution.

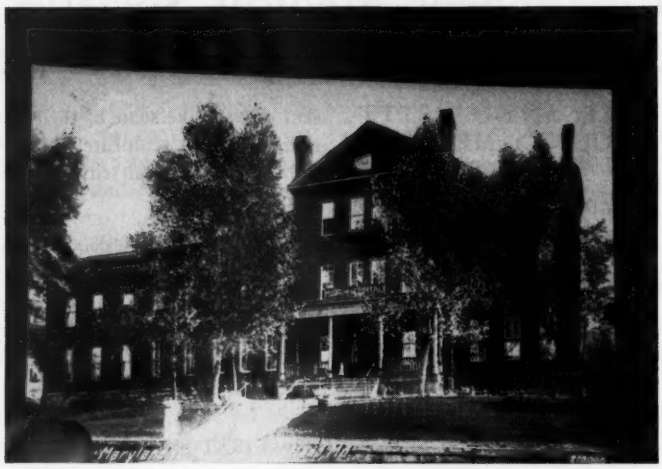
The Hospital as such, was an outgrowth and by the direct efforts of the women of Cumberland to provide a suitable place for the proper care of the sick, injured and infirm.

Four years later, the State appropriated ten thousand dollars for capital improvements and a building was erected at a cost of eighteen thousand dollars, including a mortgage of eight thousand.

In 1900, the Eastern annex was built at a cost of fourteen thousand dollars. In 1905, a laboratory was added under the direction of Dr. Charlotte B. Gardner.

By 1912, its contribution to its citizenry so stimulated its growth, that the City appropriated five hundred dollars and Allegany County six hundred dollars to its maintenance.

Ten years later, 1922, its medical staff sought



PROTESTANT HOME AND INFIRMARY
(Western Maryland Hospital)
1888–1929

recognition by the College of Surgeons and on May 25, 1922, it was reorganized and a new staff was organized under the rules of the American College of Surgeons. The new staff was as follows: Doctors Edward H. White, John E. Legge, W. R. Hodges, Sr., William L. Burns and William F. Williams, Homer Wilson, L. B. Mathews and Joseph H. Spicer, on Medical Service.

Genito Urinary: Doctors W. R. Crum, Peter S. Keim and Homer B. Walker.

Surgery: Doctors Arthur H. Hawkins, William A. Gracie, James T. Johnson, Sr., Edwin Claybrooke, John R. Littlefield and A. Leo Franklin, Frank W. Wilson, H. F. W. Warden and Winter F. Frantz.

Obstetrics: Doctors Charles L. Owens, Thomas W. Koon, J. Kyle Cowherd, L. R. Meyers, R. W. Trevaskis and Edward Harris.

Eye and Ear: Doctors Emmett L. Jones, Sr., George O. Sharrett, Howard T. Robinson, Leslie E. Daugherty and Francis P. O'Neil.

Pediatrics: Doctors Charles L. Owens and J. Kile Cowherd.

Dentists: Doctors Guy Shoemaker, Karl P. Heintz, A. P. Dixon and Charles Shoemaker.

X-Ray: Dr. Garnett Cowherd.

Pathology: Dr. Charlotte B. Gardner.

Eleven are living out of thirty-six and ten are still in active practice.

Those living today are: Doctors John E. Legge (Baltimore), William F. Williams, L. B. Mathews, Winter R. Frantz (Cumberland Health Officer), Charles L. Owens, retired, Charlotte B. Gardner, J. Kile Cowherd, L. R. Meyers, R. W. Trevaskis, Sr., Leslie E. Daugherty, and Karl P. Heintz, dentist.

MEDICAL FACILITIES IN CUMBERLAND AREA

In a thirty mile radius with Cumberland the center, there are five existing hospitals, with a bed capacity of 588. There are fifty-six physicians in all of Allegany County, or eighty-four in the ninety square miles. To the north at Bedford, Pennsylvania, an eighty-five bed hospital has been in operation, with a daily census of seventy-four beds averaging January. To the west, in Frostburg, Maryland, the Miners Hospital has a sixty-two bed capacity, with a daily average census in January of thirty and to the south, Keyser, West Virginia, a fifty-eight bed hospital with a bed capacity average census in the month of January of 59.03; while to the southeast, Romney, West Virginia has just voted to establish a general hospital in Hampshire County of forty beds, under the Hill-Burton Act.

Thus, in an area of ninety square miles and a combined population of 167,246, there are 630 potential hospital beds. There are in this area eighty-

four physicians to man the hospitals and take care of the general health and welfare, or one physician for every two thousand people.

The Eastern half of Allegany County, 284 square miles, has but one physician, and he is semi-retired. No other physician resides in the entire area between Cumberland and Hancock, Maryland. The population of this area is roughly 1,200.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

STUART M. CHRISTHILF, JR., M.D.

Journal Representative

The Anne Arundel County Medical Society held a dinner meeting January 18 at which time an election of officers was held and Dr. Phillip Briscoe was reelected President.

Dr. Martin Gross was the speaker and discussed the "Psychiatric Uses of the Drugs Thorazine and Serpasil."

The proposed Blue Cross and Blue Shield Plan for government dependents was also thoroughly discussed and on the basis of the proximity of the Navy installations in Annapolis, it was felt that the opinion from this area could be particularly useful. It is also possible here through our day to day relationship with our confreres in the Naval Medical Corps to obtain some opinion of the general reaction there. The consensus is that the Navy dependent would be very much benefited by the program and that the patient-doctor relationship both with private physicians and with the Navy medical organization would be very much improved by this proposed plan.

The other officers elected for the coming year were:

Vice President—DR. G. H. FAUBERT
Secretary-Treasurer—DR. HOWARD BEARD
Delegate to the State Convention—DR. RANDALL MCLAUGHLIN
Alternate Delegate—DR. MERTON T. WAITE
Board of Censors—DR. FRANK M. SHIPLEY
DR. SAMUEL BORSSUCK
DR. ALBERT L. ANDERSON
Journal Representative—DR. STUART M. CHRISTHILF, JR.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

Illness prevented President Grant Ward from attending the first meeting of the Executive Board on 24 January 1956. First Vice-president Dr. Frank Geraghty presided at the consideration of sixteen items on the agenda. Many had to be continued and some amounted only to interim reports, such as the status of the eviction of doctors from offices located on upper Saint Paul Street. The recent legal decision that the zoning law is not retroactive, and so exempts premises used as offices-away-from-residence prior to its enactment seems to have created a stalemate. A new ordinance may be presented to specifically permit current custom.

The attitude of the component societies was sought by the Faculty on a rush request from the AMA concerning proposed federal legislation to cover the medical-surgical care of dependents of members of the armed forces with Blue Cross and Blue Shield. The Board thought there might be some merit, and much danger, in the general idea but wanted facts on which to base a judgement. Some felt that, if it *would* do away with the highly discriminatory doctor-draft laws and let physicians take care of dependents in their own offices, instead of being drafted to do it the hard way, it might help toward a reasonable solution of this discrimination. Others stated that it was a step toward federal-socialized medicine. We should resist any attempt to let the Federal Government, State, or any non-medical authority establish fixed medical charges. Such rates as Blue Cross are minimal and well below that which is acceptable. Until labor unions, manufacturers, and other purveyors of services and commodities are put under similar ceilings the medical profession should not permit such action. The idea seemed to be that when the Government, by discriminatory draft legislation, makes the plumbers and mechanics work for half union wages with no overtime, the television and automobile manufacturers sell their products at half price—then will the doctors be justified in offering their services at half price, and not before.

At the usual dutch-treat dinner before the monthly meeting on 3 February 1956, the officers of the Cecil County Medical Society were guests of the City Medical Society, continuing this pleasant custom established by former President Koontz. President Ward introduced the Cecil County officers, e.g., Dr. Wallace Obenshain, *President*; Dr. H. Vincent Davis, *Vice-President*; and Dr. Klaus Huebner, *Secretary-Treasurer*, at the opening of the Meeting.

After reading of the Minutes and election of ten Active Members, former President Amos Koontz asked support of the Society and individuals in opposing HR 7225 now pending before the House of Representatives in Washington, D.C. He stated that this Bill was railroaded through Congress last year without debate, and barely failed of enactment into law without the Public really being aware of what it contained. It is an amendment to the Social Security Law permitting cash benefits for the totally disabled over fifty years of age. In determining "total disability" the Government, through Social Security, will, in effect, create federal-socialized medicine by decree. The Executive Board of the Society supported Dr. Koontz' stand against the principle of this pernicious Bill. He urged all who felt about it as he did to write to their Senators and Representatives, and also to Mr. Sherman Adams. He reminded us that cultists, socialists, and splinter groups always seem able to bring a lot of pressure to bear to get bills they are interested in to pass. The vast majority of citizens do nothing to guard their interests—and this is true at all legislative levels. He was roundly applauded.

Appropriate to "*National Heart Week*" Dr. Benjamin Baker, Associate Professor of Medicine, The Johns Hopkins University School of Medicine, gave the scientific part of the program. His paper, "*The Nature of Coronary Artery Disease*," presented in broad terms and with conservatism some current tides in the ideas about etiology, diagnosis, and prognosis of coronary artery disease. He stated that the ballistocardiograph might indicate something of the nature of the action of the heart. His charts showing the sex difference in incidence per decade were very clear cut. He was interrogated for nearly an hour by the interested audience after the end of his careful and thought provoking presentation.

Coffee, cocoa, cakes, and doughnuts provided by the Woman's Auxiliary to the Baltimore City Medical Society were ready and delicious as usual. Many thanks to Mrs. William Lynn and to Mrs. Raymond Rangle, co-chairmen of the Hospitality Committee.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.
Journal Representative

The Baltimore County Medical Association conducted its first meeting of 1956 at the Stafford Hotel January 18. This meeting was presided over by the Association's newly elected vice-president, Dr. William A. Pillsbury, of Timonium, because of the recent illness of the chief executive, Dr. Louis Dalmau, of Pikesville. It is hoped that Dr. Dalmau will be able to resume his duties by the time of the next scheduled meeting. Another important member of his administrative staff is the new secretary-treasurer, Dr. Charles Lee Randol, of Pikesville.

The main body of this first meeting was an illustrated presentation of dermatological lesions, with particular reference to important tumors of the skin. This was a very valuable session, and we are indebted to the speaker, Dr. Mark Hollander, dermatologist at The Johns Hopkins Hospital. It is suggested that other medical groups might profit by availing themselves of Dr. Hollander's concise lecture on this important topic.

Business-wise, the Association started the year in familiar style with brisk and informed comments with regard to several matters that will require action in the coming months. Primarily, there was considerable discussion about the proposed program of Blue Cross-Blue Shield coverage for dependents of servicemen. Dr. Clewell Howell and Dr. John Hyle, both of whom attended the January 5 conference on this topic, gave comprehensive food for thought to guide the Association in its decisions.

Next the members voted, at the suggestion of Dr. Charles Williams, heading up Public Relations for the County Association, that we again have a booth at the Timonium State Fair. Dr. James M. Bisanar and Dr. David Owens were voted in as active members; and an eminent "guest," Dr. Robert H. Riley, recently retired head of the Health Department of

the State of Maryland, was voted in as an emeritus member of the County Association, at his request.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular January meeting was held at the Frederick Hotel on the 17th. Dr. Lloyd Lewis of Washington gave a very interesting talk on tumors of the testicle. The very low incidence of malignancy reported by Dr. Lewis was most reassuring to all.

A second daughter, Wendy Sue, was born to Dr. and Mrs. Robert Furie, January 12. Her sister and brother welcomed the extra Christmas gift.

A first son, Alan Thomas was born to Dr. and Mrs. Thomas Stone, January 16. His two sisters have not quite decided how to accept this intrusion of the male.

HOSPITAL EVENTS

At the January meeting of the medical staff Dr. Albert Powell spoke on sclerema, scleredema and scleroderma. Dr. Furie discussed the paper.

At the joint meeting of the medical and pediatric departments Dr. Russell Guest spoke on diabetes in children.

At the surgical department meeting Dr. Jesse Fifer spoke on indications for and technique and complications of tonsillectomy.

At the obstetrical department meeting Dr. Harry Gray presented several cases of retained membranes.

The Clinical-pathological conference was held January 10. The case of the 49 year old woman seemed an incontrovertible case of rheumatic valvitis and myocarditis. The only factor in dispute was whether she died of acute congestive failure or massive pulmonary embolist. The autopsy revealed an extensive healed anteroseptal infarct 6 x 9 cms. with slight myocardial aneurysm formation, cause undetermined and a mural thrombosis in the right auricular appendage. One could predicate a ventricular fibrillation but the only thing we were sure of was the ensuing permanent cardiac asystole.

MONTGOMERY COUNTY MEDICAL SOCIETY

JAMES P. McCARRICK, M.D.

Journal Representative

The Medical Society met at the Norbeck Country Club on February 21, 1956, at which time Mr. Paul Dean spoke on "Preventive Estate Building."

Charles Warfield, M.D., was recently appointed by the Executive Committee to fill the unexpired term of Secretary to the Society, left vacant by the resignation of the elected secretary.

Other officers for the current year are: Robert A. Bier, M.D., *President*; Merrill M. Cross, M.D., *President-elect*; and Stephen N. Jones, M.D., *Treasurer*.

LUTHERAN HOSPITAL PRESENTS ITS ANNUAL MEDICAL-SURGICAL SYMPOSIUM, APRIL 27, 28, 1956

The Medical Association of the Lutheran Hospital of Maryland, Baltimore, Maryland, will again present its Annual Medical and Surgical Symposium on Friday, April 27th and Saturday, April 28th, 1956. The scientific program to be presented on Saturday, April 28th at the hospital will be as follows:

GEORGE CLINTON ANDREWS, M.D., Professor of Dermatology and Syphilology

Subject: Skin Cancer—Diagnosis and Treatment

LEANDRO TOCANTINS, M.D., Professor of Clinical and Experimental Medicine

Subject: The Fundamental and Clinical Aspects of Hemophilia

This program is given in conjunction with the annual Alumni Home Coming activities at the Lutheran Hospital of Maryland and will be followed by a Banquet and Intern Frolic.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

BOTULISM

LOUIS A. M. KRAUSE, M.D.*

This disease strikes very suddenly and usually causes weakness of the face muscles, the eye muscles, and muscles of swallowing, resembling a diffuse encephalitic process terminating within a matter of a few days—as a rule in death. Singularly, in spite of the gastro-intestinal tract being an avenue of entrance, diarrhea is not present. Only too frequent constipation is present.

The term Botulism is derived from a Latin name for sausage—Botulus. Undoubtedly the disease has existed from time immemorial, but of course it was not recognized as an entity as we know it today. It was identified by van Ermengem. He traced the disease at that time to infected ham. Since his day, other contaminated foods have been found to be the source of the infection. The simplest preventive is boiling any suspected food for ten minutes or more. This destroys the toxin.

In the United States, the disease carries a mortality of about sixty per cent, and it is slightly lower than this in some areas abroad. Even an antitoxin has been developed which may be of value if given early.

* Chairman, Library Committee.

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AMERICAN CANCER SOCIETY, INC.

Howard W. Jones, Jr., M.D.*

Each April, as a result of the Fund Raising Campaign of the American Cancer Society, there is usually an increased interest, on the part of many people, in having a routine examination by their doctor. The Maryland Division of the American Cancer Society, Inc. has for some time supported the routine check-up idea as a means of detecting cancer. Most physicians welcome and support this view.

This Spring, the Campaign will be built around the slogan "Fight Cancer With A Check-up and Check." This may mean that the interest in routine examinations will be even greater than is usual and we are therefore taking this occasion to remind the medical profession of Maryland that Spring Fund Raising Campaign time is at hand.

The demonstration Cancer Detection Clinics have shown that about one person in 200 will have an unsuspected early cancer. The continued improvement in the end results of the treatment of cancer of external sites supports the view that progress is being made chiefly by the detection of unsuspected cancer during routine examinations of patients who are interested in this type of health care.

* Medical Director, Maryland Division, American Cancer Society, Inc.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Fetal Death Certificate Revised

Among the principal problems in the area of maternal and infant hygiene is the wastage of pregnancy which results from death of a fetus *in utero* prior to or during delivery. Present concepts concerning this problem suggest that fetal death may be one of a series of sequelae, including such disorders as malformation, cerebral palsy and epilepsy, which are associated with definable events occurring during pregnancy.

In order to obtain more useful knowledge on the determinants of fetal death, the standard certificate of stillbirth has been revised by the National Office of Vital Statistics of the U. S. Public Health Service and is now designated as the Certificate of Fetal Death. This form, modified in a minor manner, was distributed by the Baltimore City Health Department during February to physicians known to practice obstetrics and to the directors of the general hospitals in Baltimore City. The chief changes compared with the previous certificate involve a revision of the format for securing information on the causes of fetal death and the addition of a supplemental medical data section.

The medical certification section on causes of fetal death which appears on the new fetal death record parallels closely the equivalent section on the death certificate. It is fully understood that at the present stage of knowledge concerning the causes of fetal death there are few positive guides that can be given to the physician. Therefore, the doctor is encouraged to enter information in the medical certification section on the fetal death certificate which in his judgment best explains the sequence of events leading to death. There will be instances when the clinician does not know the causal factors and "unknown" is the only honest entry that he can make. Obviously, medical knowledge will be best advanced, if whenever possible, the physician will use terms which assist in arriving at the underlying cause of fetal death. For example, if asphyxia is given as the direct cause of fetal death, it is most important that the certifying physician indicates the antecedent cause, e.g. placenta previa, if it is known to have been present as a significant factor.

Huntington Williams, M.D.

Commissioner of Health

STATE DEPARTMENT OF HEALTH

Mothers, Babies, and Hospitals

In keeping with the national pattern, Maryland has experienced a sharp rise in the number and percentage of children born in hospitals each year. In 1945, 65.7 per cent of all deliveries in Maryland took place in hospitals. In 1954 this had risen sharply to 95.2 per cent hospital delivery, including even those delivered in the most remote sections of the state.

It appears therefore that, like the automobile, hospital delivery is here to stay. Coincident with this trend has been a gratifying increase in the *safety* of childbearing. Maryland's provisional 1955 maternal mortality rate is 4.4 deaths per 10,000 live births, a record low for this state. The disconcerting fact remains, however, that in its review of maternal deaths, the Committee on Maternal and Child Welfare still consistently finds between one-half and two-thirds of all fatalities in childbearing to have been avoidable.

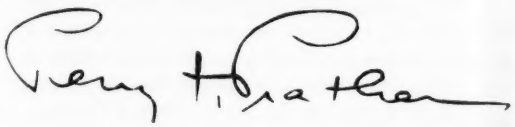
This unpleasant fact indicates that hospital delivery *per se* is not the final solution to all problems in obstetrics. Having one hundred per cent of our babies born in hospitals would not guarantee 100 per cent living mothers and children. The *quality* of hospital and professional care is the key factor.

Other disturbing aspects of the present situation are apparent. The increased number of hospital births, often in the face of personnel shortages, poses the threat of abandoning time-proven measures designed to protect the welfare and safety of mother and child. Lack of personalized attention by a sympathetic member of the hospital staff often fails to satisfy the emotional needs of women in labor or

recently delivered. Also the decrease in infants lost, either born dead or succumbing in the first few weeks of life, has not nearly paralleled the decrease in maternal mortality. This last is, after all, basically an obstetrical problem and is beginning to receive its due share of study and thought by obstetricians.

In the near future the State Department of Health will for the first time issue newly completed Regulations for Obstetrical Service in Hospitals of Maryland. This document has been prepared jointly by the Divisions of Hospital Services, Maternal and Child Health, and Public Health Nursing of the Maryland State Department of Health with the cooperation and approval of the Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty of Maryland.

The actual regulations are brief and are intended to supplement the regulations for general hospitals in pointing out certain provisions applying specifically to obstetrical services. Attached to the regulations will be an appendix entitled, "Standards and Procedures for the Care of Maternity Patients." This appendix goes into considerably more detail concerning the operation of maternity services and makes a number of important recommendations and suggestions. While these recommendations are not intended to have the same force as a regulation, they are, however, considered to be important guides toward better hospital maternity and newborn care. It is to be hoped that all hospitals receiving obstetric patients will direct their efforts toward the pattern outlined in this series of recommendations. Copies of the combined regulations and appendix will be forwarded to all appropriate hospitals for distribution to key members of the hospital staff. Any other interested physicians, nurses, or administrators may obtain copies from the Maryland State Department of Health. Suggestions concerning changes and improvements in this material will be welcomed.



Director

DEFENSE DEPARTMENT ASKS PAY RAISE FOR MEDICAL OFFICERS

THE AMA WASHINGTON LETTER, No. 84–55

The Defense Department is asking Congress to change the law to permit the crediting of 5 years of medical education and internship for all physicians entering the services, as well for doctors now on active duty. This would result in (1) the commissioning of medical officers as captains instead of first lieutenants, (2) pay increases for most medical officers, averaging $50 per month and ranging from $125 for the lowest grade to $31 for higher grades, and (3) the crediting of one additional year toward future promotions. The changes would cost about $8.4 million a year. Defense Department cited a survey showing the chief reason for resignations to be low pay compared with civilians. It said the average pay of civilian doctors in federal posts is $1,400 to $2,600 higher than that of comparable military doctors. As additional evidence that improvements are needed, the department said that in the three-year period ending in June of last year, 19,935 physicians and dentists entered service while 22,340 left. Congress was told that present high turnover among military medical officers creates "demoralizing and unsatisfactory conditions" and is "extremely expensive."

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, March 2–March 29, 1956

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	65	—	23	—	370	—	85	—	—	—	20	—	—	1	23	—	—	—	8
Anne Arundel	21	—	4	1	153	—	17	—	—	—	2	—	—	3	12	—	1	m-1	3
Howard	1	—	—	—	3	—	1	—	—	—	—	—	—	—	6	—	1	—	2
Harford	4	—	3	—	30	—	9	—	—	—	—	—	—	—	2	—	—	—	1
Carroll	1	—	—	—	26	—	5	—	—	—	1	—	—	—	1	—	—	m-1	2
Frederick	25	—	4	1	21	—	—	—	—	—	2	—	—	—	—	—	5	—	—
Washington	5	—	—	—	3	—	3	—	—	—	2	—	—	—	3	—	—	—	1
Allegany	—	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—	—	4
Garrett	—	—	—	—	14	—	3	—	—	—	2	—	—	—	—	—	—	—	—
Montgomery	44	—	6	—	170	—	29	—	—	—	19	—	—	—	7	—	2	—	2
Prince George's	26	—	8	—	118	1	13	—	—	—	5	—	—	1	13	—	1	—	6
Calvert	—	—	—	—	—	—	3	—	—	—	—	—	—	—	1	—	—	—	—
Charles	1	—	1	—	4	—	15	—	—	—	—	—	—	2	3	—	—	—	—
Saint Mary's	20	—	3	2	74	—	—	—	—	—	1	—	—	—	1	—	2	—	3
Cecil	—	—	—	—	1	—	3	—	—	—	3	—	—	—	—	2	—	—	2
Kent	2	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	1
Queen Anne's	—	—	—	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	2	—	—	—	—	—	—	—	—	—	9	—	—	1	—	—	4	—	1
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Dorchester	—	—	—	—	7	—	—	—	—	—	—	—	—	—	2	—	—	—	1
Wicomico	4	—	—	2	2	—	1	—	—	—	2	—	—	—	1	3	4	—	2
Worcester	10	—	—	—	—	—	1	—	—	—	—	—	—	2	3	—	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Total Counties	231	0	52	6	998	1	192	0	0	0	68	0	0	10	81	5	21		40
Baltimore City	189	0	69	7	1098	2	226	0	0	0	52	0	0	3	74	19	419	—	35
State																			
March 2–29, 1956	420	0	121	13	2096	3	418	0	0	0	120	0	0	13	155	24	440		75
Same period 1955	364	0	62	26	248	3	236	0	0	0	439	0	0	25	180	16	456		50
5-year median	565	1	125	45	935	9	308	2		0	275	2	2	33	199	18	491		77
Cumulative totals																			
State																			
Year 1956 to date	1289	0	258	40	6204	16	1034	1	0	0	344	1	0	51	532	82	1528		265
Same period 1955	1189	1	134	114	456	9	645	2	0	0	1481	0	0	112	476	35	1688		245
5-year median	1569	7	189	124	2220	27	781	5		0	737	5	5	134	564	60	1692		229

m = meningitis other than meningococcus.

PRESIDENT'S REPORT*
MARYLAND MEDICAL SERVICE, INC.

HENRY F. ULLRICH, M.D., *President*

We have just completed our fifth full year of operations, and it is my pleasure to report to you on the progress of Maryland's Blue Shield Plan during 1955.

Last year we experienced a substantial gain in membership in our standard program, from 162,153 to 228,466 subscribers, a net gain of 66,313, or 41%. If we include the subscribers covered under the special surgical program for Bethlehem Steel, the total membership at the end of 1955 was 344,409. This membership represents 37% of the total Blue Cross membership at the year-end.

This has been an excellent record of enrollment growth. The present enrollment under the standard plan includes 181,700 group subscribers, 41,000 who pay direct, and nearly 6,000 subscribers who have enrolled under our non-group membership program which was started in September of 1954.

We are especially pleased with the non-group results. Though this type of membership is still small numerically in relation to group enrollment, growth has been steady, and this program meets a definite need in the community.

It is fair to say, I believe, that part of our membership growth in 1955 stems from our local educational campaign, together with the advertising by Blue Shield Plans jointly in national media. Our Blue Shield program is relatively new, so our educational program has been very effective in getting information to the public about how Blue Shield can help in meeting medical expenses.

Financial growth has accompanied membership growth. Our total assets exceeded the million dollar mark in 1955, and stood at $1,228,619 at the year-end. Our total income from subscribers in 1955 was $2,882,572, and out of this we paid $2,304,506, or 79.8% in benefits to subscribers. After operating expenses, which were 10.8% of our total income, we put aside 9.4% in reserves, somewhat more than we did in 1954.

It would be natural for you to ask why Blue Shield should pay out only 80% of its income in benefits while Blue Cross paid out nearly 93% in 1955. There are several reasons. For one thing, Blue Cross rates are going up early in 1956 simply because they paid out such a high percentage in 1955. Also, it is important to remember that Blue Shield is a much younger plan, we have not as yet been able to build our reserves to necessary levels, and we are still experiencing a high rate of new enrollments with attendant limitations on certain benefits (obstetrics and tonsils and adenoids, for example). Once our new membership growth slows down, we can expect that an increasing percentage of income will be paid out for benefits.

Last year we provided benefits under our standard program to 23,305 subscribers, as compared with 16,640 receiving benefits in the previous year. Of the hospitalized cases, 57% included surgery, 30% were medical admissions, and the remaining 13% were obstetrical cases. Twenty-eight per cent of the subscribers also received benefits for anesthesia and for consultations.

In mid-1955 our Medical Director and administrative staff began work on a revision of our standard Blue Shield Plan. Our experience with both subscribers and physicians since September 1, 1952, when the present fee schedule and benefit provisions went into effect, convinced us that there was a need to make certain adjustments in the program. We wanted to eliminate inconsistencies and inequities in the fee schedules, and we felt it desirable to add certain new areas of benefits. After several months of study and discussion, and consultation with committees of physicians in the various specialties, we developed the revised program which will go into effect on May 1, 1956. Subscription rates will be increased slightly to cover the additional costs of the new benefits. We are convinced that the revised fee schedule and benefit provisions represent an important improvement in our Blue Shield program—for subscribers and doctors alike.

In the immediate future we will work on a second

* Given at the Sixth Annual Meeting of Maryland Medical Service, Inc., February 29, 1956.

Blue Shield Plan, with a higher benefit schedule and higher income limits, to be offered to groups that desire broader protection than we can now provide. Nationally, many Blue Shield Plans are now offering such higher level programs, in recognition of the generally high wage and salary levels in effect. There is no question but that our present $4,000 family income limit under which full coverage is provided is low in relation to family income levels in this area. We expect to present this higher benefit program to our Participating Physicians for their consideration within the next few months.

In closing, let me comment briefly about Blue Shield nationally. The 77 Blue Shield Plans, the majority of them partial-service programs like Maryland Medical Service, had a total membership of over 34 million at the end of 1955, gaining some three million subscribers during the year. Together these Plans paid out some $350 million in benefits for over seven million separate physicians' services. And in the areas served by Blue Shield Plans, there are 122,000 participating physicians, roughly 89% of all physicians in these areas. This is certainly a splendid record of cooperation by the medical profession.

I want to extend my sincere thanks to the members of the Board of Trustees, to the Participating Physicians in the State, and to our Blue Shield administrative staff, for their splendid cooperative effort in making 1955 such a notable year of progress for Maryland Blue Shield. I am sure that we will establish new records of growth in 1956 and in the years ahead.

AMERICAN HEART ASSOCIATION ISSUES GUIDE FOR BLOOD VESSEL BANKS

Recognizing that modern advances in the diagnosis and surgical correction of cardiovascular diseases have made procurement, preservation and implantation of blood vessel grafts an important factor in the success of such surgery, a committee of the Scientific Council of the American Heart Association has drawn up a guide for establishment and operation of blood vessel banks.

The guide, "Recommendations for the Establishment and Maintenance of a Blood Vessel Bank," is designed to aid clinical investigators in the establishment of blood vessel banks under standard conditions and to encourage a "certain uniformity in the procurement and preservation of vascular grafts for evaluations."

In addition to its discussion of techniques involved in the utilization of vascular grafts, the guide also contains a section devoted to the various types of rigid and flexible plastic grafts, noting however that "only long-term post-operative observation in human recipients will give a definitive answer on the fate of various types of vascular and plastic prothesis."

The guide also discusses the relative advantages of procurement of vascular grafts from the donor under sterile and non-sterile conditions. Sections are devoted to space requirements for banks, equipment, legal aspects of procurement, techniques, and evaluation of donor material based on age of donor, cause of death and interval between death and autopsy. Various types of sterilizing and preservative agents are described.

The recommendations for blood vessel banks were prepared for the Association's Scientific Council by a committee of four cardiovascular surgeons, Jere W. Lord, Jr., M.D., New York; Robert E. Gross, M.D., Boston; Charles A. Hufnagel, M.D., Washington, D.C.; and Abel A. Lazzarini, Jr., M.D., New York.

Single copies of the guide may be obtained by physicians from the Heart Association of Maryland, 221 East 25th Street, Baltimore—18, Maryland. Information on procuring copies of the guide in quantity may also be obtained from this source.

FLASH

FRIDAY, MAY 4, 1956

Is the

ANNUAL MED-CHI CHARITY BALL

At the

ALCAZAR

9:30 p.m. to 1 a.m.

Music—Dancing—Raffle

Have you made your reservations?

If not, call

Mrs. Newland E. Day
HOpkins 7-2977

or

Mrs. Alfred T. Nelson
HOpkins 7-9070

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. ALBERT E. GOLDSTEIN, *Auxiliary Editor*

ATTENTION!! ALL DOCTORS' WIVES!

MRS. GERALD LEVAN*

Last call for your attendance at the Seventh Annual Convention of the Woman's Auxiliary to be held at the Sheraton-Belvedere, in Baltimore, on May 2–4, 1956! With a record number of reservations, we are looking forward to a grand get-together. Don't Miss It or We'll Miss You!

The Annual State Convention is the highlight of the Auxiliary year and is an accepted obligation for all state auxiliaries. All State Officers and Chairmen, and County Presidents are expected to attend the convention along with the properly elected delegates.

The purpose of the State Convention is: (1) To review and appraise the work of the year on both state and county level; (2) to decide on the program and projects to be undertaken during the coming year; and (3) to devise plans of organizing and financing such undertakings and to choose the leaders to carry on the work.

The Convention program includes both business sessions and social events for the members, all of which we hope you will find educational, stimulating, and friendly. One of the features of the convention is that our only business meetings will be held Wednesday and Thursday morning, leaving free time to relax, renew old acquaintances, make new friends and 'go shopping' while in the city.

Mrs. Mason G. Lawson, President of the Woman's Auxiliary to the American Medical Association, will honor us with a visit and be the Guest Speaker at our Luncheon on May 2, when our husbands dine with us. Besides having Mrs. Lawson, there will be other guests whom we shall be pleased to have with us. Mrs. Edgar Quayle, of Maryland, who is a Vice President of the National organization, and the State Presidents of D.C., Delaware, New Jersey, Pennsylvania, Virginia, and West Virginia. Mrs. John O'Connell, President of the Woman's Auxiliary to the Southern Medical Association, will be our guest on Thursday, May 3.

The Auxiliary is most desirous that Every Member and Potential Member will be in attendance at our convention so we all can meet and welcome our guests. This will not only *prove* Maryland's hospitality but will assure us that our guests will return home with a good impression of the doctors' wives in our State. Please consider your presence with us a personal obligation, even if you do not yet believe our oft-repeated plea that the Auxiliary members WANT you with us.

Social Hour-Tea: On Wednesday, from 3:00–5:00 p.m. (Room to be announced later.) This will be an informal get-together which will afford you the opportunity to meet and "get to know" Mrs. Lawson and other guests, as well as other doctors' wives. We wish all of you to attend this affair, so please do not disappoint us!

The Executive Board of the Auxiliary has reserved a room in the Belvedere for the convenience and use of all women attending the Convention. This room—Parlor F on the second Floor—will be open from 9:00 a.m. to 5:00 p.m. on May 2 and 3, so please feel right "at home" in making use of this accommodation whenever and as often as you wish. It was the thought of your comfort and convenience that prompted the Board to make this gesture, and we hope you will enjoy it.

What more can I say that will convince you that we are most anxious to have you with us for the Convention? I wish I knew! Your husband will be very happy to have you accompany him, I am sure, and you will make us happy, too! We want this to be a memorable occasion and we need YOU with us to make it just that.

* President, Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland.

THE NEWEST TREND*

A splendid new Plan of Insurance is now available for Members of the Medical Society and their families. In keeping with the newest trend in the Insurance Industry, the Baltimore City Society's Board of Directors has acted favorably upon the Insurance Committee's recommendation that it adopt a Major Hospitalization and Nurse Expense Plan, often referred to as "Catastrophic Hospital Expense Insurance," for the Physician and his family.

This program is earmarked for the financially disrupting disabilities involving hospitalization and nurse expense not adequately compensated by ordinary hospitalization plans.

The Insurance Fraternity has performed with distinction its task of educating the public to the wisdom of providing, through the instrument of Insurance, the basic hospitalization costs. Many individuals have felt, however, that the available Insurance Plans were not sufficiently extensive in scope to accomplish this end so far as the bigger bills are concerned. The average hospital bill, while looming with magnitude in the eyes of many white-collar workers, is generally not of sufficient size to prove economically burdensome to the established professional man. The latter individual is, on the other hand, deeply concerned with the possibility of being faced with the necessity of financing prolonged periods of hospitalization with their accompanying variety of "monetary musts" including round-the-clock nursing (itself amounting to $315.00 per week in Maryland).

The new program, in essence, places at the disposal of each covered family member a five-thousand-dollar fund to be used for each sickness or accident. In order that the cost be kept within reach of each family the Plan has been designed somewhat along the lines of automobile collision Insurance with its $50.00- or $100.00-deductible feature. The Major Hospital and Nurse Expense Plan incorporates a $300.00-deductible provision whereby the insured provides the first $300.00 of hospital expense by either budgetary means or a basic hospitalization plan. After that the Major Expense Plan assumes the burden.

The Plan protects each individual by paying in excess of the first three hundred dollars for any charge made by a hospital and seventy-five per cent of the nurses' expense in the hospital up to five thousand dollars per disability.

One of the broad aspects of the Plan is the fact that expenses do not have to be incurred in a single period of hospitalization but rather will be covered so long as they are incurred within two years after the onset of the disability. In other words, chronic disorders are provided for in such a manner as to preclude more than one three-hundred-dollar payment on the assured's part over a two-year period.

The only exclusions in this low cost Plan are pregnancy, mental disorders, military service, war, and services of federal hospitals. It will pay in addition to basic hospitalization plans.

Of particular importance is the fact that an individual's protection may not be terminated by the Company solely on the grounds of his poor health or claim frequency.

The program is underwritten by the Continental Casualty Company and administered by Mr. James H. Pollard.

The initial enthusiastic response has been gratifying. It is hoped that word of this Plan will be spread so that it may become available to the majority of the Membership. It is believed that this plan is the answer to the Physician's long-range hospitalization Insurance requirements.

It may interest you to know that the Plan is presently restricted to three medical Societies in the entire United States, of which Baltimore City is one. As experience develops, it is probable that the benefits of this new Catastrophic Hospital Expense Insurance Plan may even be improved.

* Reprinted with minor changes from an editorial in the Philadelphia County Medical Society, by Joseph W. Post, Chairman, Insurance Committee.

Coming Meetings

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, May 17, 1956, 5:00 to 6:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty of the State of Maryland

MATERNAL MORTALITY COMMITTEE

HUNTINGTON WILLIAMS, M.D., *Chairman* IRVIN M. CUSHNER, M.D., *Secretary*

Thursday, May 24, 1956, 4:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department

PENNSYLVANIA ACADEMY OF GENERAL PRACTICE

EIGHTH ANNUAL CONVENTION

Bedford Springs, Pennsylvania, May 18, 19, and 20, 1956

This meeting will combine a Scientific Session with planned and organized activities for the wives and children. For further information write Pennsylvania Academy of General Practice, 27 Baltimore Street, Mt. Holly Springs, Pennsylvania.

POSTGRADUATE COURSE TO BE GIVEN BY THE DEPARTMENT OF MEDICINE AT JOHNS HOPKINS HOSPITAL

May 7 to 12, 1956

"Topics in Clinical Medicine," a six-day postgraduate course for physicians primarily interested in internal medicine, will be sponsored by the Department of Medicine at The Johns Hopkins Hospital.

For further information concerning the course, contact Dr. Philip A. Tumulty, Course Chairman, The Johns Hopkins Hospital, Baltimore 5, Maryland.

THE MONTH IN WASHINGTON

WASHINGTON, D.C. OFFICE OF THE AMERICAN MEDICAL ASSOCIATION

All too frequently overlooked in Congressional activity on health and related bills each year are the little-publicized but highly important appropriations measures—without which no program of the federal government could move forward. The appropriations hearings in the House (where all money bills must originate) rarely get headlines they are conducted behind closed doors. Weeks and some times months later, the hearings are published, but by then the bill supplying money for an agency has been reported to the House.

It's only when the measure gets to the Senate that private groups and individuals are heard—by then in open sessions. Closed House sessions are not new. That is the way it has been done ever since Congress set up a separate committee on appropriations back in 1865.

The importance of appropriations in running the federal government was clearly illustrated when the President submitted to Congress his 1,272-page budget message in which he sought $65.9 billion for all federal programs for the fiscal year beginning July 1.

While there was no overall total of projected spending by all the agencies in the health field, the budget requests for the Department of Health, Education, and Welfare showed a sharply upward trend. And if certain new legislation is voted on this session—like the projected 5-year program of construction grants for medical schools and private laboratory facilities—the total figure for subsequent years is likely to be even higher.

On the medical school-laboratory construction bill, the President asked Congress for $40 million for the first year (estimated cost over five years is $250 million). Construction grants, which would have to be matched on a 50-50 basis, would be available for private medical schools as well as non-federal laboratories conducting research into a wide range of crippling diseases.

The budget message also calls for another $30 million in outright grants, to the states to help them in financing poliomyelitis vaccination programs, the same amount appropriated by Congress last session. The administration in a separate request asked for extension of the polio law, from February 15, 1956 to June 30, 1957, and both the House and Senate with only brief debate voted the 17-month extension. Since only half of last year's $30 million was spent up to the February 15 expiration date of the original act, there was no rush for Congress to act on the new account.

Other new spending asked by the administration, contingent, of course, on enabling legislation, includes $10 million for initial capitalization of mortgage loan guarantees for health facilities; $5 million for graduate and practical nurse and professional health personnel training, $3 million for water pollution grants; $1.5 million for mental health expansion programs; and $1 million for sickness and disability surveys in the United States.

If Congress approves the requests, virtually all segments of the Department of HEW will have more money to spend than in this fiscal year. None would benefit more, however, than the medical research arm of government, the National Institutes of Health. The total sought for the seven institutes in 28% more than estimated spending this year. Here are some examples: National Cancer Institute, $32,437,000, up 29%; National Heart Institute, $22,106,000, up 17%, and the National Institute of Allergy and Infectious Diseases (formerly the National Microbiological Institute), $9,799,000, a 26% increase.

The President requested $130 million for the Hill-Burton hospital-clinic construction program which will be ten years old this August. In this connection Congress has been asked to extend the act for two years beyond next year, and action is expected this session.

NOTES

After a study of possibilities in the peaceful uses of atomic energy, a panel has recommended, among other things, that the U. S. encourage states and private organizations to take full advantages of the opportunities offered by radioactive material for medical research and treatment.

It now appears that an improved and more uniform program of medical care for service families will be adopted this session—possibly before this is published. One feature: A $25 deductible charge in civilian hospitals, but with the government paying the full insurance premium, and mandatory subsistence charge in military hospitals.

Making slower progress is the plan—under consideration for more than a year—for a health insurance program for U. S. civilian workers. Here the government would pay about half the cost.

Several committees are urging stricter penalties and other changes to bring the illicit narcotic traffic under better control; so far no suggestion of more controls over the medical profession in the handling of narcotics.

IMPROVEMENTS FORECAST IN ADMINISTRATION HEALTH PROPOSALS

The AMA Washington Letter, No. 84-47

Roswell Perkins, Assistant Secretary of HEW, says the administration's health program for next year will contain revisions and improvements over the program submitted to Congress during the last session. Addressing the District of Columbia League of Republican Women on November 15, Mr. Perkins noted that 88% of hospital beds in the U.S. are taken up by the chronically ill and that "we should plan ahead" in this field. He also declared:

"While hearings were held on a few of these measures, most were given no consideration. Our program for next year, which is not finalized, will contain revisions and improvements in the total program. But the question will again be squarely presented as to whether this Congress will enact the bulk of the President's health program."

SALK VACCINE PRODUCTION TO INCREASE SOON, PHS SAYS

The AMA Washington Letter, No. 84-47

Lagging production of the Salk poliomyelitis vaccine should start picking up in December and reach normal production rate probably in February, Surgeon General Scheele predicted November 17. He blamed the recent drop in production on major changes made last May in vaccine production and testing, and on continuing refinements since then. Dr. Scheele made the estimates in submitting to HEW Secretary Marion Folsom an interim report of the Public Health Service's Technical Committee on Poliomyelitis Vaccine. The committee reported the following:

1. New filtration techniques remove clumps of virus particles which were large enough to shield some virus from the action of formaldehyde, and now expose all the virus to formaldehyde inactivation.

2. Monkey safety tests have been modified to increase sensitivity, and the monkey potency test has been revised so that it serves as an additional safety test. Points 1 and 2, along with continuous review of plant production records, assure the safety of released vaccine and should make more supplies available, according to the report.

3. Vaccine properly made by the Mahoney strain, while especially virulent, provides "an entirely safe immunizing agent." Research is continuing in the hope of finding a less virulent strain.

DEFENSE DEPARTMENT OFFERS NEW DEPENDENT CARE BILL

The AMA Washington Letter, No. 84–54

A new bill for the medical care of dependents of military and other services was introduced on the opening day of Congress by Chairman Vinson of the House Armed Services Committee. Prepared by Defense Department at the request of Mr. Vinson, it is the third version of the proposal, which has been pending in Senate and House for nearly a year. Still more amendments are expected to be made in committee after Defense Department obtains data from Blue Cross and Blue Shield Commissions and private insurance companies.

At this juncture, the measure (H.R. 7994) includes these major points:

1. Authorizes medical care for dependents of members of the Armed Forces and of Coast Guard, Coast and Geodetic Survey and Public Health Service personnel on active duty.

2. Medical care would include diagnosis, treatment of acute medical and surgical conditions and contagious disease, immunization and maternity and infant care.

3. The family would have the choice of care directly from the military medical service, if facilities were available, or protection through insurance. The family selecting the insurance method could obtain care from private sources, or it could still use military facilities. The uninsured family receiving direct care from the military could be charged fees for outpatient care, and would be charged subsistence and possibly other costs while in the hospital, expenses that would be paid by the insurance plan in the case of an insured dependent. Thus the extent of these charges (to be set by the military) would determine whether direct military care or insurance would be the most advantageous financially. Insurance companies or plans would pay rates to be set, by Defense Department for care of insured dependents at military facilities.

4. Service families selecting insurance would pay 30% of the cost of a basic plan for wife and children, but the entire cost of coverage for dependent parents and parents-in-law. However, parents and parents-in-law would be eligible for care in military facilities on the same basis as wives and children. Where hospitalization or other benefits are exhausted under a basic plan, the dependent could be transferred to a military facility, or if that were not feasible the government would pay the additional costs for private care.

5. Unlike the earlier Defense Department version, no provision is made for a "home-town care" plan for dependents. That bill allowed use of civilian facilities for dependents not covered by insurance, with the government paying part of the cost. No equivalent protection is provided under the new bill.

6. As in previous bills, dependents are defined as lawful wife, unmarried legitimate children under 21, parents and parents-in-law if dependent for half of support. Also eligible would be unmarried widows and dependent children of servicemen who were eligible at the time of his death.

Chairman Vinson of the House Armed Services Committee has referred the bill to a subcommittee under Rep. Paul J. Kilday (D., Texas), with instructions to expedite hearings.